MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9421

Reg. Dist. No. 09413

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 847-BERKSHIRE DR.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md.
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 52 HYATTSVILLE
d. STREET ADDRESS: 1847-BERKSHIRE DR
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First JOSEPH Middle ABRAHAMS Last

4. DATE OF DEATH: Month AUG. Day 1 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1887

9. AGE (In years last birthday): 74 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): CLERK

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov.

11. BIRTHPLACE (State or foreign country): N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: MARKS ABRAHAMS

14. MOTHER'S MAIDEN NAME: AMELIA HELLER

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

INFORMANT Address: MRS JOSEPH ABRAHAMS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): (Third attack) Aortic Aneurysm.
DUE TO (c): Hypertension Arteriosclerosis — 10yrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 4: 3, 1961, to 8: 1, 1961, that I last saw the deceased alive on 8: 1, 1961 and that death occurred at 7 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Stanley Paul Porton M.D. ADDRESS (Street, city or town, state): 300-Hamilton St. NW. DATE SIGNED

PHYSICIAN'S NAME (Type): STANLEY PAUL PORTON

22a. BURIAL, CREMATION, REMOVAL (Specify): 8-3-61

22b. DATE THEREOF

22c. NAME OF CEMETERY OR CREMATORY: BAYSIDE CEMETERY

22d. LOCATION (City, town, or county) (State): QUEENS N.Y

23. FUNERAL DIRECTOR'S SIGNATURE: B Benjamin Hyson ADDRESS: 3501-14 ST NW

24a. REC'D BY REGISTRAR DATE: AUG 4 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filled by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9422

(19414)

1. PLACE OF DEATH
a. COUNTY: PrinceGeorges — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: PrinceGeorges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 20 min
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 3 Hyattsville

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital
d. STREET ADDRESS: 4811 70th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maud Middle: E Last: Banker
4. DATE OF DEATH: Month: August Day: 30 Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 7 Jan 1882
9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Washington D.C,
12. CITIZEN OF WHAT COUNTRY?: U.S,

13. FATHER'S NAME: Robert V McKenney
14. MOTHER'S MAIDEN NAME: Laura Hunt.

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Russell Banker - Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute coronary occlusion — INTERVAL BETWEEN ONSET AND DEATH: 2 h
DUE TO (b): 420.0 Arteriosclerotic heart disease — 7 yrs
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-30 1961, to 8-30 1961, that (I) (we) last saw the deceased alive on 8-30 1961, and that death occurred at 6:30 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Till Bergmann M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED
22c. PHYSICIAN'S NAME (Type): Dr. Till Bergmann, M.D.
22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 9-1-61
23c. NAME OF CEMETERY OR CREMATORY: Congressional
23d. LOCATION (City, town, or county) (State): Washington D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: J Wm Lee & Sons
ADDRESS: 300 H St N.E.
25a. REC'D BY REGISTRAR DATE: SEP 5 '61
25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9423

CERTIFICATE OF DEATH

Item 14 from birth certif. 8/31/61

09415

1. PLACE OF DEATH
a. COUNTY: Prince George' — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheveryl
c. LENGTH OF STAY IN 1b: 2 Hr
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): W. Hyattsville
d. STREET ADDRESS: 3208 Toledo Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy — Middle — Last: Bantz

4. DATE OF DEATH: Month: Aug. — Day: 24 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 23, 1961

9. AGE (In years last birthday) yrs.

IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours: 2 — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Robert L Bantz

14. MOTHER'S MAIDEN NAME: Jane Lee Jenkins

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Fetal atelectasis — INTERVAL BETWEEN ONSET AND DEATH: 14 hrs.

DUE TO (b): Prematurity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

762.5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year — Hour a. m. p. m. — 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 23 1961 to Aug. 24 1961, that (I) (we) last saw the deceased alive on Aug. 24 1961, and that death occurred at 2:10 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Julius Kauffman, M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/24/61

22c. PHYSICIAN'S NAME (Type): Julius Kauffman, M.D.

22d. ADDRESS: 5102 Annapolis Road, Bladensburg, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-29-61

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town, or county) (State): Cheverly, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator — ADDRESS

25a. RECD BY REGISTRAR DATE: AUG 31 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

M C I

20772 2.2. XVI

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9424

CERTIFICATE OF DEATH

09416

1

M

I

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 75 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Oakcrest

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Pr. George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Laurel
d. STREET ADDRESS: Oakcrest
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary — Middle: — Last: Beall

4. DATE OF DEATH: Month: August — Day: 23 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: April 11, 1869

9. AGE (In years last birthday): 92 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: unknown

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Mrs Agnes Whitehead, Laurel Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Bronchopneumonia
DUE TO (b): Acute Staph Virus
DUE TO (c): Gen'l arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4221

INTERVAL BETWEEN ONSET AND DEATH: 3 days

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Cystitis -

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

MEDICAL CERTIFICATION

21. **I certify** that (I) (this hospital) attended the deceased from 2/14, 1961 to 8/23, 1961, that (I) (~~we~~) last saw the deceased alive on 8/22, 1961, and that death occured at 5 A.M, from the causes and on the date stated above.

22a. SIGNATURE: J M Warren M.D.

22b. DATE SIGNED

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22c. PHYSICIAN'S NAME (Type): J. M. WARREN

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 25, 1961

23c. NAME OF CEMETERY OR CREMATORY: St Mary Cem.

23d. LOCATION (City, town or county) (State): Laurel, Md

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: DeWitt Donaldson, Laurel, Md

25e. REC'D BY REGISTRAR DATE: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Howe

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Item 7 Film G293 8/22/61 mh

9425

CERTIFICATE OF DEATH

Item 2 Film G293 8/23/61 iwk

09417

Reg. Dist. No.

1. PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) RFD
c. LENGTH OF STAY IN 1b

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Washington 28 DC (2) Md. Suitland
d. STREET ADDRESS 299 Swann Rd. 6501 Marcey Rd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Prince Georges Co Rest Home

3. NAME OF DECEASED (Type or print) First Ella Middle L. Last Belk

4. DATE OF DEATH Month Aug Day 14 Year 1961

5. SEX Fem

6. COLOR OR RACE Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH Oct 8 1906

9. AGE (In years last birthday) 54 yrs.

IF UNDER 1 YEAR: Months | Days
IF UNDER 24 HRS.: Hours | Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic

10b. KIND OF BUSINESS OR INDUSTRY Retired

11. BIRTHPLACE (State or foreign country) UNK

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME UNK

14. MOTHER'S MAIDEN NAME UNK

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)

16. SOCIAL SECURITY NO. None

17. INFORMANT Address Records Prince Georges Co. Rest Home

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute Coronary Occlusion
420.1
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b) Arteriosclerotic Cardiovascular
DUE TO (c) Renal disease

INTERVAL BETWEEN ONSET AND DEATH
a hr
b year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Natural Causes

20c. TIME OF INJURY Hour a. m. p. m. Month Day Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1961 to Aug 14, 1961, that I last saw the deceased alive on Aug 12, 1961, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Paul C Vannatta M.D. ADDRESS (Street, city or town, state) 5420 Silver Hill Rd SE DATE SIGNED

PHYSICIAN'S NAME (Type) PAUL C VANNATTA Washington 28 DC Aug 14 1961

22a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL

22b. DATE THEREOF 8-15-61

22c. NAME OF CEMETERY OR CREMATORY Rest Home Cemetery

22d. LOCATION (City, town, or county) (State) Forestville, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS The Hunt Funeral Home, Wilmot, Md

24a. REC'D BY REGISTRAR DATE AUG 18 '61

24b. REGISTRAR'S SIGNATURE Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9426 — 09418

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5803 15th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Jerome — Middle: William — Last: Betts
4. DATE OF DEATH: Month: August — Day: 1, — Year: 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: March 24, 1944
9. AGE (In years last birthday): 17 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Student
10b. KIND OF BUSINESS OR INDUSTRY: High school
11. BIRTHPLACE (State or foreign country): New York
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John Henry Betts
14. MOTHER'S MAIDEN NAME: Catherine Megenedy

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: John H. Betts, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ASPHXIA — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Drowning
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Known Epileptic

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Fell into pond while fishing.
20c. TIME OF INJURY — Hour a.m.: about 10:30xx — Month, Day, Year: 1 Aug 1961
20d. INJURY OCCURRED — While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): In a wooded Area
20f. (City or town): Chillum (County): Park P.G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☐ Accident ☒ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.
Address (Street, city, town, or county):
DATE SIGNED: August 1, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b. DATE THEREOF: 8-5-1961
22c. NAME OF CEMETERY OR CREMATORY: St. JOHNS CEMETERY
22d. LOCATION (City, town, or country): QUEENS COUNTY, NEW YORK. (State):

23. FUNERAL DIRECTOR — ADDRESS: W. W. CHAMBERS CO., Riverdale, Maryland.
24a. REC'D BY REGISTRAR: AUG 4 '61
24b. REGISTRAR'S SIGNATURE: Corinne I Thomas

MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9427 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09419

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 4801 Madison Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Calvin — Middle: William — Last: Billings

4. DATE OF DEATH: Month: August — Day: 28, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 4, 1892

9. AGE (In years last birthday): 69 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Billings

14. MOTHER'S MAIDEN NAME: Polly Moxley

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: 225-28-1665

17. INFORMANT — Address: Ethel Maude Billings, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 420 Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Coronary Heart Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: August 28, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8-31-1961 — 22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM — 22d. LOCATION (City, town, or country) (State): BLADENSBURG, MARYLAND

23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. Riverdale, Maryland

24a. REC'D BY REGISTRAR — DATE: AUG 30 '61 — 24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if an autopsy is necessary, please file the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 of the [illegible] director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9428 Information from birth cert. 09420

1. PLACE OF DEATH a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Laurel
d. STREET ADDRESS: Box 204
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle: ; Last: Bond

4. DATE OF DEATH: Month: Aug. Day: 11 Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 8, 1961

9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months: 3 Days; IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Everett Jones

14. MOTHER'S MAIDEN NAME: Veronica Delia Bond

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother Veronica Bond, Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Prematurity — INTERVAL BETWEEN ONSET AND DEATH:

762.5 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): atelectasis

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 8 1961, to Aug. 11, 1961, that (I) (we) last saw the deceased alive on Aug. 11 19 61, and that death occurred at 6:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John W. Perkins M.D. — ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: August 15, 1961

22c. PHYSICIAN'S NAME (Type): John W. Perkins, M.D.

22d. ADDRESS: 5301 Hamilton St., Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8-23-61

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town, or county) (State): Cheverly, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr. ADDRESS: Administrator

25a. REC'D BY REGISTRAR DATE AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

28 7 1 B 2 1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4) ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9429 09421

1

M

C

1

1

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 3022 Kenilworth Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Boy; Middle:; Last: Brown

4. DATE OF DEATH: Month: August; Day: 16; Year: 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16, 1961

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: ; Days: ; IF UNDER 24 HRS: Hours: 4; Min.: 23

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Prince George's County

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Donald Brown

14. MOTHER'S MAIDEN NAME: Josephine Barnes — Address: Same

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ~~Prematurity~~ Atelectasis
7625
DUE TO
(b) Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 hrs. & 23 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from August 16, 1961, to August 16, 1961, that (I) (we) last saw the deceased alive on August 16 1961, and that death occurred at 7:13 M. from the causes and on the date stated above.

22a. SIGNATURE: John Perkins M D

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Dr. John Perkins, M.D.

22d. ADDRESS: 5301 Hamilton St. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8/23/61

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town, or county) (State): Cheverly, Md

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr.

ADDRESS: Administrator

25a. REC'D BY REGISTRAR DATE: AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kness

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9430 CERTIFICATE OF DEATH

Reg. Dist. No. 09422

1. PLACE OF DEATH
a. COUNTY: Pr. George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Hgts.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 2902 - Breton Dr.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Pr. George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Hgts.
d. STREET ADDRESS: 2902 Breton Dr.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: MRS. ADA Middle: R. Last: BROWN
4. DATE OF DEATH: Month: 8 Day: 20 Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Jan. 18-1884
9. AGE (In years last birthday): 77 yrs
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: none
11. BIRTHPLACE (State or foreign country): Mo.
12 CITIZEN OF WHAT COUNTRY: USA
13. FATHER'S NAME: Andrew J. Rogers
14. MOTHER'S MAIDEN NAME: Katy Mallette
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO.:
17 INFORMANT: Frank P. Brown Address: Same 2 d

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH: 20 MIN.
DUE TO
(b): Arteriosclerotic Heart Disease
DUE TO
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)
19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 8-14, 1961, to 8-20, 1961, that I last saw the deceased alive on 8-20, 1961, and that death occurred at 11:35 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: W B Sheer M.D. ADDRESS (Street, city or town, state): 7200 MARLBORO PIKE, WASH. 28, D.C. DATE SIGNED: 8-20-61
PHYSICIAN'S NAME (Type): WALTER B. SHEER M.D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Cremation
22b. DATE THEREOF: 23 Aug '61
22c. NAME OF CEMETERY OR CREMATORY: Lee's Crematory
22d. LOCATION (City, town, or county) (State): Washington, D.C.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Lee Funeral Home - Washington D.C.
24a. REC'D BY REGISTRAR DATE: AUG 22 '61
24b REGISTRAR'S SIGNATURE: Arthur S Kruger

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9431

CERTIFICATE OF DEATH

09423

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: md
b. COUNTY: Puince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): + Cheverly
d. STREET ADDRESS: 3007 Laurel Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: James — Middle: — Last: Buckley

4. DATE OF DEATH: Month: Aug — Day: 10 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: white

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: July 30, 1908

9. AGE (In years last birthday): 53 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civilian Intelligence Agt.

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: James Buckley

14. MOTHER'S MAIDEN NAME: Elizabeth Schmidt

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mildred E Buckley — Address: Cheverly, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CARCINOMATOSIS — INTERVAL BETWEEN ONSET AND DEATH: 6 mos

DUE TO (b): Bronchogenic Carcinoma — 1 yr

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 162.1

DUE TO (c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a m / p. m — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from MAY 19 58 to 8/10 19 61, that (I) (we) last saw the deceased alive on 8/10 1961, and that death occurred at 3:35 PM, from the causes and on the date stated above

22a. SIGNATURE: Norman Dewt Comeau M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 8/10/61

22c. PHYSICIAN'S NAME (Type): Norman Dewt Comeau

22d. ADDRESS: 3503 Penny St MT Rainier Md.

23a. BUR A., CREMAT ON REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 14, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Evans

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9432 — Reg. Dist. No. 09424

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
c. LENGTH OF STAY IN 1b: 11 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6508 FLANDER ORIVE

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 6508 Flander Drive
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Edward — Middle Lucien — Last Burgess

4. DATE OF DEATH: Month Aug. — Day 15 — Year 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: May 16, 1871

9. AGE (In years last birthday): 90 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): FARMER

10b. KIND OF BUSINESS OR INDUSTRY: FARM

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Hezekiah Burgess

14. MOTHER'S MAIDEN NAME: [redacted] SARAH BUSSEY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): NO — (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: none

17. INFORMANT: Mrs. Leslie Burgess Rehrey — Address: 6508 Flander Dr. Hyattsville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Congestive Heart Failure	2 Weeks
DUE TO (b)	Arteriosclerotic Heart Disease	8 years
DUE TO (c)	Generalized Arteriosclerosis	15 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a. m. / p. m., Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Dec. 1957 to Aug. 15, 1961, that I last saw the deceased alive on Aug. 12, 1961, and that death occurred at 7:15 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Laubach M.D. — ADDRESS (Street, city or town, state): 1806 FOX St. — DATE SIGNED: 8/15/61

PHYSICIAN'S NAME (Type): JAMES L. LAUBACH — Hyattsville, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 18, 1961

22c. NAME OF CEMETERY OR CREMATORY: Warrenton, Va

22d. LOCATION (City, town, or county) (State): Warrenton, Va.

23. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: W W Lautrell 3603 4½ St. NW

24a. RECD BY REGISTRAR — DATE: AUG 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kness

1

M

I

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

A 15 1
9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9433 — 09425

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2 USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7314 Halleck St.,
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Harry — Middle: Wilson — Last: Burnham

4. DATE OF DEATH: Month: Aug. — Day: 6 — Year: 1961

5 SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐, NEVER MARRIED ☒, WIDOWED ☐, DIVORCED ☐

8. DATE OF BIRTH: June 2, 1909

9. AGE (In years last birthday): 52 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Bartender

10b. KIND OF BUSINESS OR INDUSTRY: Restaurant

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Harry Burnham

14. MOTHER'S MAIDEN NAME: Sarah Johnson

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): Yes — WWII

16. SOCIAL SECURITY NO:

17 INFORMANT Address: Byron Burnham, Charlotte Hall, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH: 12 Hr

420.0

Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriscloritic Heart Disease — 10 Years

DUE TO (c): Bronchial Asthemis — Years

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m — Month, Day, Year 19

20d INJURY OCCURRED While at work ☐ Not while at work ☐

20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from ____ 19__ to Aug. 6 1961, that (I) (we) last saw the deceased alive on Aug. 6 1961, and that death occurred at 3:10A M. from the causes and on the date stated above

22a SIGNATURE: Peter Duus M.D

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b DATE SIGNED: Aug. 6-61

22c. PHYSICIAN'S NAME (Type): Dr. Peter Duus. M.D.

22d ADDRESS: 6124 Centeral Ave., Capitol Heights, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-9-61

23c. NAME OF CEMETERY OR CREMATORY: Old Fields

23d. LOCATION (City, town, or county) (State): Hughesville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: The Huntt Funeral Home, Waldorf, Md.

25a REC'D BY REGISTRAR DATE: AUG 10 '61

25b REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A15 (4) 15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9434

CERTIFICATE OF DEATH

09426

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN MARYLAND: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1124 Girard St., N. W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mary; Middle: -; Last: Burns

4. DATE OF DEATH: Month: 8; Day: 23; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 8/31/1884

9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months: -; Days: -
IF UNDER 24 HRS.: Hours: -; Min.: -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unknown

10b. KIND OF BUSINESS OR INDUSTRY: Unknown

11. BIRTHPLACE (County & State, or foreign country): Unknown

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Lloyd Price

14. MOTHER'S MAIDEN NAME: Elizabeth ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Decedent
Address: -

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident, left — INTERVAL BETWEEN ONSET AND DEATH: 20 hrs.,
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO: Cerebral arteriosclerosis — Unknown
(c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Generalized arteriosclerosis, arteriosclerotic heart disease; pneumonitis, left lower lobe, resolving.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 8/18/ 9:05 61 to 8/23/, 1961, that (I) (we) last saw the deceased alive on 8/23/ 19 61, and that death occured at P. M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8/23/1961

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): 8-26-61

23b. DATE THEREOF

23c. NAME OF CEMETERY OR CREMATORY: Woodlawn Cemetery

23d. LOCATION (City, town or county): Hillcrest Rd SE DC (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Mahan-Schaydre

ADDRESS: 424 R St NW

25a. RECEIVED BY REGISTRAR DATE: AUG 29 61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9435

CERTIFICATE OF DEATH

09427

1. PLACE OF DEATH
a. COUNTY Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN this place 4 mos- 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince Georges

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) College Park
d. STREET ADDRESS 8404 49th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: Doshia Middle: A Last: Canton
4. DATE OF DEATH Month: August Day: 31 Year: 19 61
5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH 10-12-06
9. AGE (In years last birthday) 54 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (County & State, or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME Samuel Downs
14. MOTHER'S MAIDEN NAME Hattie Embrey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) no
16. SOCIAL SECURITY NO. no
17. INFORMANT Robert F. Canton--College Park, Md. Address 8404 49th Avenue

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) [illegible] Fungized Carcinoma
DUE TO (b) Cancer of Cervix
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)
INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from ..... 19 , to ..... 19 ..., that (I) (we) last saw the deceased alive on ..... 19 and that death occured at 5:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE A. Deitz M.D.
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED September 1, 1961
22c. PHYSICIAN'S NAME (Type) Aaron Deitz, M.D.
22d. ADDRESS 4314 Gallatin St., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify) Burial
23b. DATE THEREOF 9/5/61
23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.-- Arlington, Virginia
23d. LOCATION (City, town or county) (State)
24 FUNERAL DIRECTOR'S SIGNATURE A. H. Hines
ADDRESS 2901 14th St. NW
25a. REC'D BY REGISTRAR DATE SEP 5 '61
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After ... certificate has been signed by the attending physician and ... entered in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. ... pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9436 Reg. Dist. No. 09428

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2mo. 14 da.
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: 8910 Riggs Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: N.Y. b. COUNTY: Orange
c CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Highland Mills
d STREET ADDRESS: 697-2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sister St. Casilda Middle: Laura Caron Last:
4. DATE OF DEATH: Month: August Day: 1 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 28,1891
9. AGE (In years last birthday): 70 yrs. IF UNDER 1 YEAR: Months Days IF UNDER 24 HRS.: Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Roman Catholic Nun
10b KIND OF BUSINESS OR INDUSTRY: Religious Order
11 BIRTHPLACE (State or foreign country): Rhode Island
12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Achille
14 MOTHER'S MAIDEN NAME: Victoria Houle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17. INFORMANT: Address: M. Mary Armand, R.J.M.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Massive intestinal hemorrhage — INTERVAL BETWEEN ONSET AND DEATH: 15 min.
154 X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Carcinoma of the Rectum — 2 years
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from May 17, 1961, to Aug. 1, 1961, that I last saw the deceased alive on July 28, 1961, and that death occurred at 4:00 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: James L. Laubach M.D. ADDRESS (Street, city or town, state): 180 E FOX St, Hyattsville, Md. DATE SIGNED: 8/1/61
PHYSICIAN'S NAME (Type): JAMES L. LAUBACH

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-4-61
22c. NAME OF CEMETERY OR CREMATORY: REGINA CONVENT CEM.
22d LOCATION (City, town, or county) (State): HYATTSVILLE MARYLAND

23 FUNERAL DIRECTOR'S SIGNATURE: [signature] ADDRESS: WASH.D.C.
FRANCIS J. COLLINS 3821 14th. ST.N.W.

24a REC'D BY REGISTRAR DATE AUG 4 '61
24b REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death: Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, page 3 should be detached for use of the burial-transit permit. Then please remove carbon papers. The funeral director should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9437

CERTIFICATE OF DEATH

09429

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 19 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 4305 Eastern Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3 NAME OF DECEASED (Type or print): First: Rumsey — Middle: ELIAS — Last: Cave

4. DATE OF DEATH: Month: August — Day: 18 — Year: 19 61

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 31 Jan 1894
9 AGE (In years last birthday): 67 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ACCOUNTANT retired
10b. KIND OF BUSINESS OR INDUSTRY: WASHINGTON GASCO
11. BIRTHPLACE (State or foreign country): VIRGINIA
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: WILLIAM CAVE
14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes no or unknown) (If yes, give war or dates of service): UNKNOWN
16. SOCIAL SECURITY NO.: 577-07-7467
17 INFORMANT: ROBERT H. CAVE. Address: 1906 GAINSBORO RD ROCKVILLE, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hepatic Failure — INTERVAL BETWEEN ONSET AND DEATH: 1 month
DUE TO (b): Cirrhosis of the Liver — unknown
Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Chronic Bronchitis - Emphysema
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from June, 1960 to Aug, 1961, that (I) (we) last saw the deceased alive on Aug 17 1961 and that death occurred at 4:30 AM from the causes and on the date stated above.

22a SIGNATURE: Benjamin S. Miller M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: Aug 18 1961
22c PHYSICIAN'S NAME (Type): Dr. B. Miller., M.D.
22d. ADDRESS: 3824-34 St Mt Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b DATE THEREOF: AUG 21, 1961
23c NAME OF CEMETERY OR CREMATORY: WASHINGTON NATIONAL
23d. LOCATION (City, town, or county) (State): SUITLAND, MARYLAND

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers — ADDRESS: Riverdale, Md.
25a. REC'D BY REGISTRAR DATE: AUG 23 '61
25b REGISTRAR'S SIGNATURE: Arthur S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9438

CERTIFICATE OF DEATH

09430

1. PLACE OF DEATH
a. COUNTY: PRINCE GEO — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): OXON HILL
c. LENGTH OF STAY IN 1b: 22 YEARS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 1921 - owens rd S.E

2 USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEO
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 17 OXON HILL
d. STREET ADDRESS: 2001 OWENS RD SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First EMMA Middle R. Last CROSSINGHAM

4. DATE OF DEATH: Month Aug Day 12 Year 1961

5 SEX: FEMALE
6 COLOR OR RACE: WHITE
7 MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: JULY-3-1881
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months / Days / Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY: DOMESTIC
11. BIRTHPLACE (State or foreign country): MARYLAND
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JOHN CUSICK
14. MOTHER'S MAIDEN NAME: SARAH A-A-OWENS

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16 SOCIAL SECURITY NO: NONE
17 INFORMANT: EVELYN C. O'DONNELL Address: 1921 OWENS RD S.E.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): [illegible] — INTERVAL BETWEEN ONSET AND DEATH: [illegible]
DUE TO (b): [illegible]
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July [illegible], 19[illegible], to [illegible] 19[illegible], that (I) (we) last saw the deceased alive on [illegible] 19[illegible] and that death occurred at [illegible] M. from the causes and on the date stated above.

22a SIGNATURE: [illegible] M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED
22c PHYS CIAN'S NAME (Type): LEWIS PARKER
22d. ADDRESS: 5241 - St Barnabas Rd Temple Hills Md.

23a BURIAL CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: aug 16-61
23c NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d LOCATION (City, town, or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE: [illegible] Bros ADDRESS: 1601-9d Hope Rd S.E. Washington DC
25a REC'D BY REGISTRAR DATE AUG 15 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (II) 1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9439 **CERTIFICATE OF DEATH** 19431

1 M

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRENTWOOD
c. LENGTH OF STAY IN 1b: 40 YRS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4401 40th ST.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGES
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): BRENTWOOD
d. STREET ADDRESS: 4401 40TH ST.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First CLARA Middle ANNIE Last DALY

4. DATE OF DEATH: Month AUG Day 23, Year 1961

5. SEX: FEMALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☒ **DIVORCED** ☐

8. DATE OF BIRTH: JAN 16, 1882

9. AGE (In years last birthday): 79 yrs.
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS.: Hours ___ Min. ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): AUDITOR

10b. KIND OF BUSINESS OR INDUSTRY: U.S. GOVERNMENT

11. BIRTHPLACE (County & State, or foreign country): BRIGHTON ILLINOIS

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

I

13. FATHER'S NAME: AMOS DANIEL CULP

14. MOTHER'S MAIDEN NAME: LOUISA CHAPMAN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: MRS LUCILE SHORES
Address: 3203 NICHOLSON ST HYATTSVILLE, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Thrombosis
DUE TO (b): Cardiovascular disease
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1/2 hr. / 1 year

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/10 19 61, to 8/23 19 61, that (I) (we) last saw the deceased alive on 8/22 19 61, and that death occured at 5:55 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Earl W. Graeff M.D.

ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-23-61

22c. PHYSICIAN'S NAME (Type): EARL W. GRAEFF, M.D.

22d. ADDRESS: 2716 Kirkwood Pl. W. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): ENTOMBMENT

23b. DATE THEREOF: AUG 26, 1961

23c. NAME OF CEMETERY OR CREMATORY: FT. LINCOLN MAUSOLEUM

23d. LOCATION (City, town or county) (State): BLADENSBORG, MARYLAND

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co.
ADDRESS: Riverdale, Md

25a. REC'D BY REGISTRAR DATE: AUG 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinnear

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9440 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09432

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 3404 Upshur
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Creed — Middle: Alexander — Last: Davis

4. DATE OF DEATH: Month: Aug. — Day: 23 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Aug. 22, 1885

9. AGE (In years last birthday): 76 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Carpenter

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Fernando Davis

14. MOTHER'S MAIDEN NAME: Mary Ann Chapman

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 579-05-8119

17. INFORMANT: 4311 Newark Road Thomas Leedy, Colmar Manor, Md

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure

420.1

DUE TO (b): Coronary Heart Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town or county)

DATE SIGNED: Aug. 23, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-27-1961

22c. NAME OF CEMETERY OR CREMATORY: West End Cemetery

22d. LOCATION (City, town, or country) (State): Wytheville, Virginia

23. FUNERAL DIRECTOR: W. W. Chambers Co. — ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 25 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Fraser

TO DEPT. MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please explain the certificate, write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9447 — 09433

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Please complete and forward to the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN MARYLAND: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George General

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5504 42 nd Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: James; Middle: C.; Last: Dawson

4. **DATE OF DEATH**: Month: August; Day: 26; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 7 July 1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR — Months: ; Days: ; IF UNDER 24 HRS. — Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Life Insurance agent Retired

10b. KIND OF BUSINESS OR INDUSTRY: Home Mutual co

11. BIRTHPLACE (County & State, or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give were or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT: Harriett Dawson Address: Hyattsville Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cancer of Bladder
DUE TO (b): Metastasis Liver & Pancreas
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, off ce bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 20 Aug 1961 to 26 Aug 1961 that (I) (we) last saw the deceased alive on 25 Aug 1961, and that death occurred at 3:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: A W McLaurin, MD M.D.

22b. DATE SIGNED: Aug 26, 1961

22c. PHYSICIAN'S NAME (Type): A. W. McLaurin

ATTENDING PHYS. ☒ MED D RECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: 4637 Eastern Avenue, Washington, 18, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 28, 1961

23c. NAME OF CEMETERY OR CREMATORY: George Washington

23d. LOCATION (City, town or county) (State): Hyattsville, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9442 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 19434

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linda Knolls
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 7500 Doris Drive

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Linda Knolls
d. STREET ADDRESS: 7510 Doris Drive S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Michael Middle: James Last: DeMarco
4. DATE OF DEATH: Month: August Day: 15 Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: march 12, 1957
9. AGE (In years last birthday): 4 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Wash. D.C.
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Eugene V. DeMarco
14. MOTHER'S MAIDEN NAME: Mary G. Miller
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: Eugene V. DeMarco, Father Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Drowning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1a

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.): Fell in an open pit rear of 7500 Doris Drive
20c. TIME OF INJURY Hour: 4:15 p.m. Month, Day, Year: 8/15/61
20d. INJURY OCCURRED While at work ☐ Not While at work ☒
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Lot
20f. (City or town): Linda Knoll (County): P.G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county):
DATE SIGNED: 8/15/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/18/61
22c. NAME OF CEMETERY OR CREMATORY: Arlington National
22d. LOCATION (City, town, or country): Fort Myer Virginia (State): Virginia

23. FUNERAL DIRECTOR: W. N. Chambers & Inc. ADDRESS: 517-11th St SE Wash, D.C.
24a. REC'D BY REGISTRAR DATE: AUG 18 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 to the next of kin. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9443

CERTIFICATE OF DEATH

Reg. Dist. No. 09435

1. PLACE OF DEATH
a. COUNTY Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Hgts
c. LENGTH OF STAY IN 1b: 24 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 6211 L st

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md
b. COUNTY Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Hgts 2
d. STREET ADDRESS 6211 L st
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Mary Middle Lucinda Last Dillard

4. DATE OF DEATH: Month Aug Day 22 Year 1961

5. SEX: F

6. COLOR OR RACE: C

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 6-7-1875

9. AGE (In years last birthday): 86 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Wash. D.C

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John Sutton

14. MOTHER'S MAIDEN NAME: Miss Mary Lucinda Gray

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO

17. INFORMANT: James T. Sutton — Address: 6211 L st

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 4 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Cardiovascular Cerebral Accident — 14 days

DUE TO (c): Arteriosclerotic Hypertensive Disease — 6 mos

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour o. cl. p. m. Month, Day, Year

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Aug. 7, 1961 to Aug. 21, 1961, that I last saw the deceased alive on Aug. 21, 1961, and that death occurred at 6.40 P.M. from the causes and on the date stated above.

ACTUAL SIGNATURE: Lewis H. Kurtz M.D. — ADDRESS (Street, city or town, state): 2727 6th St. N.E. — DATE SIGNED: 8-22-61

PHYSICIAN'S NAME (Type): Lewis H. Kurtz, M.D. — 727 6th St., N.E. — 8-22-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-26-61

22c. NAME OF CEMETERY OR CREMATORY: Mt Olivet

22d. LOCATION (City, town, or county): Washington (State): D.C.

23. FUNERAL DIRECTOR'S SIGNATURE: Henry S Wagner Sons — ADDRESS: 4925 Deane Ave

24a. REC'D BY REGISTRAR DATE AUG 24 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Furnie

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

Item 18 Film 293 9-1-61
Item 2 Film 305 1-1-62

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9444 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09436

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mitchellville
c. LENGTH OF STAY IN 1b: 20 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Rip's Motel

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland Virginia — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton Richmond
d. STREET ADDRESS: Southern Maryland Medical Center — RESIDENCE OR FARM?

3. NAME OF DECEASED (Type or print): First: Albert — Middle: William — Last: Eldridge

4. DATE OF DEATH: Month: August — Day: 23 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARR.ED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 7, 1932

9. AGE (In years last birthday): 29 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Physician

10b. KIND OF BUSINESS OR INDUSTRY: Medicine

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: ROBERT M. ELDRIDGE

14. MOTHER'S MAIDEN NAME: ELAINE YEAST

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): YES (If yes, give war or dates of service): Korean

16. SOCIAL SECURITY NO.: 434-44-878

17. INFORMANT: PEARL E. ELDRIDGE, Address: 3114 PARKWOOD AVE. RICHMOND, VA.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): SEVERE PULMONARY EDEMA
DUE TO (b): pending Acute barbiturate poisoning
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour a.m. / p.m. — Month, Day, Year — 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒ and in my opinion death resulted from. Natural causes ☐. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☒

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 8/23/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8/28/61

22c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATL. CEM.

22d. LOCATION (City, town, country): FORT MYER (State): VIRGINIA

23. FUNERAL DIRECTOR: W.W. CHAMBERS CO. — ADDRESS: RIVERDALE, MD.

24a. REC'D BY REGISTRAR DATE: AUG 29 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is unknown, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 of the certificate to any funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9445

CERTIFICATE OF DEATH

09437

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 01 Laurel
d. STREET ADDRESS: 1103 Snowden Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: George; Middle: ; Last: Ellis

4. DATE OF DEATH: Month: Aug. 19; Day: ; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Apr. 6, 1902

9. AGE (In years last birthday): 59 yrs.
IF UNDER 1 YEAR: Months: ; Days: — IF UNDER 24 HRS: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): groom

10b. KIND OF BUSINESS OR INDUSTRY: race track

11. BIRTHPLACE (State or foreign country): Massachusetts

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: ? Ellis

14. MOTHER'S MAIDEN NAME: Sarah ?

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO.: 026-14-2369

17. INFORMANT: Hospital records. Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 4 days
DUE TO (b): Uremia
DUE TO (c): Diabetes Mellitus — year

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause ost.

260X

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug. 15, 1961 to Aug. 19, 1961, that (I) (we) last saw the deceased alive on Aug. 19 1961, and that death occurred at 6:50 P.M. from the causes and on the date stated above.

22a SIGNATURE: W H Clements M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS ☒
22b DATE SIGNED

22c PHYSICIAN'S NAME (Type): W. H. CLEMENTS

22d. ADDRESS

23a. BURIAL CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug. 22 1961
23c. NAME OF CEMETERY OR CREMATORY: United Syrian Cem.
23d. LOCATION (City, town or county) (State): Lawrence Massachusetts

24. FUNERAL DIRECTOR'S SIGNATURE: William Donaldson
ADDRESS: Laurel Md

25a. REC'D BY REGISTRAR DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Curtis L. Thomas

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9446

CERTIFICATE OF DEATH

09438

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death

VR A1S (4)
15M 9/59

1 PLACE OF DEATH a. COUNTY: Prince George's — MARYLAND	2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission) a. STATE: Maryland b. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md	c. LENGTH OF STAY IN 1b: 1 year
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville Md.	
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 6900 Calverton Drive.	d STREET ADDRESS: 6900 Calverton Drive — e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print)	First: BESSIE	Middle	Last: ENGEL	4. DATE OF DEATH	Month: Aug	Day: 22	Year: 19 61
5. SEX: F	6 COLOR OR RACE: White	7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	8 DATE OF BIRTH: Jan 4, 1889	9. AGE (In years last birthday): 72 yrs	IF UNDER 1 YEAR: Months / Days	IF UNDER 24 HRS.: Hours / Min	

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired	10b. KIND OF BUSINESS OR INDUSTRY: Southern Railroad Co.	11. BIRTHPLACE (State or foreign country): Maryland	12 CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Theodore Paul Engel	14. MOTHER'S MAIDEN NAME: Mary Dance

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): no	16. SOCIAL SECURITY NO.: none	17. INFORMANT: Mrs Grace White	Address: Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Pulmonary Congestion — INTERVAL BETWEEN ONSET AND DEATH: 2 days

170X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Carcinoma Left breast c. — 4 yr 7

DUE TO (c): metastasis to lungs & liver

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)				
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)

21 **I certify** that (I) (this hospital) attended the deceased from June 19 61 to Aug 19 61, that (I) (we) last saw the deceased alive on Aug 22 19 61, and that death occurred at [illegible] M, from the causes and on the date stated above.

22a SIGNATURE: [signature] M D	ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐	22b DATE SIGNED	
22c PHYSICIAN'S NAME (Type): W. L. Tilman	22d. ADDRESS: Cox-92 Fork Md Rte 3		

23a BURIAL, CREMATION, REMOVAL (Specify): Burial	23b DATE THEREOF: Aug 25, 1961	23c NAME OF CEMETERY OR ~~CREMATORY~~: Ft Lincoln Cemetery	23d LOCATION (City, town, or county): Colmar Manor, Md.	(State)

24. FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons	ADDRESS: Hyattsville, Md.	25a. REC'D BY REGISTRAR DATE AUG 24 '61	25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

3 1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9447 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09439

Item 9 Film G292 5/11/61 lwk

1. PLACE OF DEATH
a. COUNTY Prince George's MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Height's
c. LENGTH OF STAY IN 1b 25 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) 1111 - 64th Street

2. USUAL RESIDENCE (Where deceased lived, If institution Residence before admission)
a. STATE Maryland b. COUNTY P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cedar Heights
d. STREET ADDRESS 1111 - 64 Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First: Mary Middle: Louise Last: Ennis

4. DATE OF DEATH Month: Aug Day: 6 Year: 1961

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐

8. DATE OF BIRTH June 24, 1894

9. AGE (In years last birthday) 67 Yrs. 11 Mos. IF UNDER 1 YEAR Months / Days IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife

10b. KIND OF BUSINESS OR INDUSTRY Own Home

11. BIRTHPLACE (State or foreign country) Maryland

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME Charles Fenton Winters

14. MOTHER'S MAIDEN NAME Laura Marshall

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service) No

16. SOCIAL SECURITY NO.

17. INFORMANT Mrs Fannie Brown Address 1108-64 St Cedar Heights

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure

DUE TO (b) Cardio vascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of Injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑ Inquiry ☑, and in my opinion death resulted from: Natural causes ☑ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D.

EXAMINER'S NAME (Type) JAMES I BOYD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county)

DATE SIGNED 8-6-61

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF 8-10-61

22c. NAME OF CEMETERY OR CREMATORY Nat. Harmony

22d. LOCATION (City, town, or country) Highland Park (State) Md.

23. FUNERAL DIRECTOR Henry S. Washington ADDRESS 4925 Deane Ave N.E.

24a. REC'D BY REGISTRAR DATE AUG 9 '61

24b. REGISTRAR'S SIGNATURE Clifton L. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any examination is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9448 — 09440

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANGLEY PARK
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address):

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MD
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LANGLEY PARK SG
d. STREET ADDRESS: 1404 Merrimac Dr
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Samuel — Middle: W. — Last: Farran

4. DATE OF DEATH: Month: August — Day: 7 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: SEPT. 18 1879

9. AGE (In years last birthday): 81 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): RETIRED

10b. KIND OF BUSINESS OR INDUSTRY: TAVERN OWNER

11. BIRTHPLACE (County & State, or foreign country): MD

12. CITIZEN OF WHAT COUNTRY?: USA.

13. FATHER'S NAME: JOHN FARRAN

14. MOTHER'S MAIDEN NAME: UNKNOWN.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): BLANCHE V FARRAN 1404 Merrimac Dr

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 420.1 Coronary insufficiency
DUE TO (b): Coronary occlusion
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 6 months several years

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Jan. ..... 1952 to Aug. ..... 1961, that (I) (we) last saw the deceased alive on August 4 1961, and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: John N. Andrews — M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): John N. Andrews

22d. ADDRESS: 9601 Colesville Rd Silver Spring Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/10/61

23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill Cemetery

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Deal Funeral Home 4812 Hamilton NW

25a. REC'D BY REGISTRAR DATE: AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kinna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa[illegible] may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9449 **CERTIFICATE OF DEATH** C9442

1 (M) (I)

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 12 days

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4717 41st Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hosp.

3. NAME OF DECEASED (Type or print): First: Moses Middle: Ford Last:

4. DATE OF DEATH: Month: Aug. Day: 21 Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 10-12-1890

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Hospital Records Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 48 hrs

DUE TO (b): Kidney failure — 3 wks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last — DUE TO (c): Chronic kidney infection — 4 wks

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 9, 1961, to Aug. 21, 1961, that (I) (we) last saw the deceased alive on Aug. 21 1961, and that death occured at 11:05 AM, from the causes and on the date stated above.

22a. SIGNATURE: Ronald E. Krum M.D. ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Ronald E. Krum, M.D.

22d. ADDRESS: 4408 Queensbury Rd. Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/25/1961

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: W Ernest Harris # 178

ADDRESS: 1432 1/2 O St

25a. REC'D BY REGISTRAR DATE: AUG 25 '61

25b. REGISTRAR'S SIGNATURE: [illegible] S. Krum

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be filed within 24 hours after death. Pending filing the certificate may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and delivered by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

FOR STATE HEALTH DEPT

M

I

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any item is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9450 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0944-1

1. PLACE OF DEATH
a. COUNTY: Prince Georges County MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fletchertown
d. STREET ADDRESS: Rural
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERT Middle LEE Last FORD

4. DATE OF DEATH: Month August Day 21, Year 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 10, 1881

9. AGE (In years last birthday): 80 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer Ret.

10b. KIND OF BUSINESS OR INDUSTRY: Penn. RR.

11. BIRTHPLACE (State or foreign country): Charles County, Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Ford

14. MOTHER'S MAIDEN NAME: Margaret Fender

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: None

17. INFORMANT: William Winfield, Address: Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Heart Failure

DUE TO (b): Cardio vascular Renal Disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county):

DATE SIGNED: August 21, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 8-24-61

22c. NAME OF CEMETERY OR CREMATORY: Ascension Ch. Cem.

22d. LOCATION (City, town, or country): Bowie (State) Md.

23. FUNERAL DIRECTOR: Henry S. Washington & Son ADDRESS: 4925 Dean

24a. REC'D BY REGISTRAR DATE: AUG 24 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9451

CERTIFICATE OF DEATH

Item 4 Film G299 11/1/61 iwk & 22b.

09443

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston Md.
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address OR INSTITUTION): 5114 Crittenden Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Edmonston
d. STREET ADDRESS: 5114 Crittenden Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Rosa; Middle: Markham; Last: Fowler

4. DATE OF DEATH: Month: August; Day: 20; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: April 17, 1878

9. AGE (In years last birthday): 83 yrs
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Kentucky

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Markham

14. MOTHER'S MAIDEN NAME: Sarah Caldwell

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no
(If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: --

17. INFORMANT: Beulah L. Fowler — Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Arteriosclerotic Heart disease

DUE TO: associated with Congestive Heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last:
(b)
DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour; a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (~~this hospital~~) attended the deceased from Jan 1961 to Aug 18 1961, that (I) (~~we~~) last saw the ~~deceased~~ alive on Aug 18 1961, and that death occurred at 5A M. from the causes and on the date stated above.

22a. SIGNATURE: Barry Rosenberg — M.D.

ATTENDING PHYS X ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: Aug 19, 1961

22c. PHYSICIAN'S NAME (Type): Barry Rosenberg

22d. ADDRESS: 5102 Annapolis Road, Bladensburg, Md.

23a. BURIAL CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/22/61

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery

23d. LOCATION (City, town, or county): Colmar Manor, (State): Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Francis Gasch's Sons — ADDRESS: Hyattsville, Maryland

25a. REC'D BY REGISTRAR DATE: AUG 23 '61

25b. REGISTRAR'S SIGNATURE: Curtiss L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9452 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09444

1. PLACE OF DEATH
a. COUNTY Maryland ~~Prince George~~ MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Cheverly
c. LENGTH OF STAY IN 1b D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE Maryland b. COUNTY Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 13 Oxon Hill
d. STREET ADDRESS 6707 Palmer Road S.E.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print) First: Easter Middle: Mabel Last: Fox

4. DATE OF DEATH Month: 8 Day: 10 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: January 24, 1887

9. AGE (In years last birthday): 74 yrs. IF UNDER 1 YEAR Months: Days: IF UNDER 24 HRS. Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House Wife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edwin Speight

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Harvey Fox, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 472 X — Acute congestive heart failure

DUE TO (b) — Cardiovascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Severe diabetic of long standing

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [ ], Inspection [X] Inquiry [X] and in my opinion death resulted from Natural causes [X], Accident [ ], Suicide [ ], Homicide [ ], Undetermined manner [ ]

SIGNATURE James I. Boyd M.D.

EXAMINER'S NAME (Type) James I. Boyd

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

DATE SIGNED August 10, 1961

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-14-61

22c. NAME OF CEMETERY OR CREMATORY: Md. Church Cemetery-Oxon Hill

22d. LOCATION (City, town, or country) (State): Oxon Hill, Maryland

23. FUNERAL DIRECTOR: Mr. Gaskins.

ADDRESS: Washington, D.C.

24a. REC'D BY REGISTRAR DATE: AUG 15 '61

24b. REGISTRAR'S SIGNATURE: Carlton S. Rhines

John T. Rhines & Company 3015 12th St. N.E.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. If autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9453

CERTIFICATE OF DEATH

09445

M

C

I

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 1 HR 55 MIN
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: DISTRICT OF COLUMBIA
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 1381 SAVANNAH PLACE SE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JEFFREY; Middle; Last FRANCO

4. DATE OF DEATH: Month AUGUST; Day 15; Year 19 61

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 AUGUST 1961

9. AGE (In years last birthday): yrs.; IF UNDER 1 YEAR: Months, Days; IF UNDER 24 HRS.: Hours 1, Min. 55

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: JESUS FRANCO

14. MOTHER'S MAIDEN NAME: SYLVIA A JASSO

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) NO (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: NONE

17. INFORMANT: FATHER; Address: SAME AS ITEM #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY
(a) IMMEDIATE CAUSE: Prematurity with Extreme immaturity
DUE TO
(b)
DUE TO
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH: 1 hr 55 min.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 15 Aug 1961, to 15 Aug 1961, that (I) (~~saw~~) last saw the deceased alive on 15 Aug 1961, and that death occured at 0335 P.M., from the causes and on the date stated above.

22a. SIGNATURE: John A Moore M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22b. DATE SIGNED: 15 Aug 61

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 17 AUG 1961

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City, town or county) (State): ARLINGTON VA

24. FUNERAL DIRECTOR'S SIGNATURE: [illegible] ADDRESS: [illegible]

25a. REC'D BY REGISTRAR DATE: AUG 17 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9454

CERTIFICATE OF DEATH

09446

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1SM 9/60

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
c. LENGTH OF STAY IN 1b: 2yrs. 3 mos.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): R#3 Box 379

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PR. GEO.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
d. STREET ADDRESS: R#3 Box 379
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First AUGUST Middle CHRISTIAN Last FRANK

4. DATE OF DEATH: Month AUG. Day 10 Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 5-1876

9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months ____ Days ____
IF UNDER 24 HRS.: Hours ____ Min. ____

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): ARCHITECT

10b. KIND OF BUSINESS OR INDUSTRY: SELF-EMPLOYED

11. BIRTHPLACE (County & State or foreign country): GERMANY

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: CHRISTIAN FRANK

14. MOTHER'S MAIDEN NAME: MARIE KOHLMER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: 205-09-7124

17. INFORMANT: WIFE MARIE FRANK Address: R#3 Box 379 CLINTON, MD

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 2½ HRS.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): ARTERIO-SCLEROTIC CARDIOVASCULAR DISEASE — 15 yrs +
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): NONE

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER): NONE

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): NONE

20c. TIME OF INJURY: Hour NONE Month, Day, Year ____ 19__ a.m. p.m.

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, or public bldg., etc.): NONE

20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from AUG. 10, 19 61 to PRESENT, that (I) (~~saw~~) last saw the deceased alive on AUG. 10 19 61, and that death occured at 11:45 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Arthur Shaver Jr. M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: Aug 10, 1961

22c. PHYSICIAN'S NAME (Type): ARTHUR SHAVER JR. M.D.

22d. ADDRESS: BRANCH AVE. CLINTON, MD.

23a. [illegible] CREMATION, (Specify)

23b. DATE THEREOF: Aug 11-61

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town or county) (State): Bladensburg Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Simms Bros

ADDRESS: 1661-gd Hypered SE

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: Carlton L. Kramer

last 20 Dec

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09447

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN Hospital: 2 hours
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hosp

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Charles
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Marbury
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Emma — Middle: (N.M.N.) — Last: Gale

4. DATE OF DEATH: Month: 8/8/61 — Day — Year: 19

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: November 15/07

9. AGE (In years last birthday): 53 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Teacher

10b. KIND OF BUSINESS OR INDUSTRY: Schools

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William H. Gale

14. MOTHER'S MAIDEN NAME: Emma Collier

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 214-38-2563

17. INFORMANT: Mildred Gale Crump. 505 Sachem Drive Forest Heights, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Fracture of the base of the skull — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.): Lost control of her car and it overturned on the road

20c. TIME OF INJURY Hour: 5:34 m. Month, Day, Year: 8/8/61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Route 301

20f. (City or town) (County) (State): Upper Marlboro P.G. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒ Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/9/61

Address (Street, city, town, or county):

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/12/1961

22c. NAME OF CEMETERY OR CREMATORY: Parkwood Cemetery

22d. LOCATION (City, town, or country) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR: Earhart Funeral Home Inc. ADDRESS: La Plata, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 15 '61

24b. REGISTRAR'S SIGNATURE: Evelyn L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. Any delay is necessary, please explain the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9455 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09448

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 4113 - 34th., Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hazel; Middle: Irene; Last: Gilbert

4. DATE OF DEATH: Month: August; Day: 25; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: November 8, 1901

9. AGE (In years last birthday): 59 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Charwoman

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Gov't.

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Richard Reynolds

14. MOTHER'S MAIDEN NAME: Annie Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Norman K. Gilbert
Address: 2310 Ware Road Falls Church, Va.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): F4 2 X — Acute Pulmonary Edema
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Caogestive heart failure
DUE TO
(c): Cardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county)

DATE SIGNED: August 25, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/28/61

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

22d. LOCATION (City, town, or country) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR: Nalley's Funeral Home Inc.
ADDRESS: Mt. Rainier Md.

24a. REC'D BY REGISTRAR
DATE: AUG 30 '61

24b. REGISTRAR'S SIGNATURE: Elton S. Howes

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9457 Items 12, 13 & 14 Film 3294 7/61 mh 09449

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5401. Joan Lane

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills
d. STREET ADDRESS: 5401. Joan Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Margaret — Middle: T. — Last: Goodwin

4. DATE OF DEATH: Month: August — Day: 26. — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17. 1874

9. AGE (In years last birthday): 87 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): England

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James McKeon

14. MOTHER'S MAIDEN NAME: Unknown Fergerson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Edwin A. Goodwin — Address: 5401. Joan Lane

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Occlusion — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic Heart Disease

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5-10-61 19..., to 8-26 19 61, that (I) (we) last saw the deceased alive on 8-25 19 61, and that death occured at 4 A.M., from the causes and on the date stated above.

22a. SIGNATURE: Lawrence Phillips

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8-26-61

22c. PHYSICIAN'S NAME (Type): Lawrence V. Phillips

22d. ADDRESS: 503 - 11th St. S E. Wash. D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8.29.61

23c. NAME OF CEMETERY OR CREMATORY: Forest Glade; Cemetery

23d. LOCATION (City, town or county) (State): Somersworth. New. Hampshire

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: Lee. Funeral. Home 300. 4th st N E. Wash, D C

25a. REC'D BY REGISTRAR: AUG 29 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa[illegible] may be retained at hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and [illegible] by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9458

CERTIFICATE OF DEATH

Item 4 Film 6293 8/23/61 mh

09450

1. PLACE OF DEATH
a. COUNTY Montgomery (Prince George's) MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park
c. LENGTH OF STAY IN 1b 6 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 711 Colby Ave,

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Montgomery
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Takoma Park, Md.
d. STREET ADDRESS 711 Colby Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First Samuel Middle W. Last Green

4. DATE OF DEATH Month August Day 9 Year 1961

5. SEX male
6. COLOR OR RACE C
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH July 29 1880
9. AGE (If years last birthday) 81 yrs.
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Minister
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) Virginia
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME Thomas Green
14. MOTHER'S MAIDEN NAME Mary ? Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT Mrs Louise Green Jones Address Item # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Coronary Thrombosis

DUE TO (b) Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) Chronic Nephritis no edema

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a) Arthritis

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II at item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 2 1961 to Aug 9 1961, that (I) (we) last saw the deceased alive on Aug 9 1961, and that death occurred at 1 P M. from the causes and on the date stated above.

22a. SIGNATURE Webster Sewell M.D.
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED 8.12.61
22c. PHYSICIAN'S NAME (Type) WEBSTER SEWELL
22d. ADDRESS Norbeck Norwood Rd Silver Spg. Md

23a. BURIAL, CREMATION REMOVAL (Specify) Burial
23b. DATE THEREOF 8/12/61
23c. NAME OF CEMETERY OR CREMATORY National Harmony Cem.
23d. LOCATION (City, town, or county) Md (State)

24. FUNERAL DIRECTOR'S SIGNATURE Robert L. Snowden
ADDRESS Rockville, Md
25a. REC'D BY REGISTRAR DATE AUG 16 '61
25b. REGISTRAR'S SIGNATURE Arthur J. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this item has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9459 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09451

FOR STATE HEALTH DEPT.

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Parking lot at 5150 Bennings Rd

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Suitland
d. STREET ADDRESS: 3122 Parkway Terrace
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Leroy — Middle: — Last: Greenwald
4. DATE OF DEATH: Month: August — Day: 29 — Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: July 25, 1906
9. AGE (In years last birthday): 55 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Plumber
10b. KIND OF BUSINESS OR INDUSTRY: Retired
11. BIRTHPLACE (State or foreign country): District of Columbia
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Herman Greenwald
14. MOTHER'S MAIDEN NAME: Mary Willmott
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
16. SOCIAL SECURITY NO. (If yes give war or dates of service): Navy
17. INFORMANT — Address: Patricia Bowman, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): LOBAR PNEUMONIA
4 9 1 X
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐
20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY: Hour a.m. p.m. — Month Day Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
DATE SIGNED: 8/29/61
Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 9/1/61
22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln
22d. LOCATION (City, town, or country) (State): Bladensburg, Md.
23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. 517 11th St. SE
24a. REC'D BY REGISTRAR — DATE: SEP 5 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Files 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9460 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09452

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: Dead on arrival
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: New York
b. COUNTY: Kings
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brooklyn
d. STREET ADDRESS: 1677 E. 52nd. Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Joseph; Middle: Patrick; Last: Griffin

4. DATE OF DEATH: Month: August; Day: 20; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 8, 1881

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Painter

10b. KIND OF BUSINESS OR INDUSTRY: Foreman

11. BIRTHPLACE (State or foreign country): Ireland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO. (If yes give wer or dates of service): UNKNOWN

17. INFORMANT: Russell F. Griffin 16 M Ridge Road Greenbelt, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO
(b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: August 21, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 24, 1961
22c. NAME OF CEMETERY OR CREMATORY: Holy Cross Cem.
22d. LOCATION (City, town, or country) (State): Brooklyn, New York

23. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: Riverdale, Md

24a. REC'D BY REGISTRAR DATE: AUG 23 '61

24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any case within 72 hours after death.

VS. AISME SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9461 — 09453

1. **PLACE OF DEATH**
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN: 12 yrs.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 300 Washington Blvd.

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
d. STREET ADDRESS: 300 Washington Blvd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby — Middle: Cook — Last: Griffin

4. DATE OF DEATH: Month: August — Day: 3 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 22, 1918

9. AGE (In years last birthday): 43 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): North Carolina

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: Harrison Cook

14. MOTHER'S MAIDEN NAME: Julia Bange

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): no

16. SOCIAL SECURITY NO

17. INFORMANT: Howard Griffin — Address: 300 Wash. Blvd Laurel, Md.

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
+ 45X
DUE TO (b): Chronic glomerulonephritis, nephrosis.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): Hypertension, malignant.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20e. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20a. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from....., 19..., to....., 19....., that (I) (we) last saw the deceased alive on.....19....., and that death occured at.....M, from the causes and on the date stated above.

22a. SIGNATURE: Idolo Pierandrei, M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): I Dolo Pierandrei

22d. ADDRESS: 305 Prince George - Laurel, Md.

23a. BURIAL CREMATION REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 6, 1961

23c. NAME OF CEMETERY OR CREMATORY: Bethlehem Cem.

23d. LOCATION (City, town or county) (State): Elkin, North Carolina

24 FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson

ADDRESS: Laurel, Md

25a. REC'D BY REGISTRAR DATE AUG 9 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pe[illegible] may be retained by [illegible] hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and c[illegible]tely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9462

CERTIFICATE OF DEATH

119454

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Kentucky
b. COUNTY: Kentucky
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Shelbyville
d. STREET ADDRESS: 520 Magnolia Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

SEX - F

3. NAME OF DECEASED (Type or print): First: Agnes — Middle: H Anna — Last: Guthrie

4. DATE OF DEATH: Month: August — Day: 5 — Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: 12 July 1885
9. AGE (In years last birthday): 75 yrs
IF UNDER 1 YEAR: Months 0 Days 24 — IF UNDER 24 HRS: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Kentucy
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: John Hannah
14. MOTHER'S MAIDEN NAME: Betty Gay

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT: James Guthrie — Address: 702 Magnolia Ave Shelbyville Ky

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Hypotension, Cardiogenic type — INTERVAL BETWEEN ONSET AND DEATH: 12 HOURS
DUE TO (b): ACUTE MYOCARDIAL INFARCTION — 2 DAYS
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c): ATHEROSCLEROTIC HEART DISEASE — UNKNOWN

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): NONE

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 8/3, 19 61, to 8/5, 19 61, that (I) (we) last saw the deceased alive on 8/5, 19 61, and that death occurred at 7:40 pm from the causes and on the date stated above

22a. SIGNATURE: C. James Duke M.D.
ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: 8/5/61
22c. PHYSICIAN'S NAME (Type): C. JAMES DUKE, MD.
22d. ADDRESS: 6607 RIVERDALE RD, RIVERDALE, MD.

23a BURIAL, CREMATION, REMOVAL (Specify): Trans & Burial
23b. DATE THEREOF: 8/8/61
23c NAME OF CEMETERY OR CREMATORY: Grove Hill Cemetery
23d LOCATION (City, town, or county) (State): Shelbyville Kentucky

24. FUNERAL DIRECTOR'S SIGNATURE: Calvert Dunphy — ADDRESS: 7557 Wisc Ave Bethesda Md
25a REC'D BY REGISTRAR DATE: AUG 9 '61
25b REGISTRAR'S SIGNATURE: Cathryn S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director's office, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 11/59

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9463 Reg. Dist. No. 19455

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5008 36th Av.

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 5008 36th ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ROBERTA Middle O. Last HALE

4. DATE OF DEATH: Month AUG Day 5 Year 1961

5. SEX: Female

6. COLOR OR RACE: Caucasian

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Nov 10, 1880

9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (State or foreign country): VIRGINIA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: JOHN W. BAUCKMAN

14. MOTHER'S MAIDEN NAME: ELLA JOHNSON

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: MRS ORRA SPENCER Address 5008-36th AVE HYATTSVILLE MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Coronary — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Arteriosclerosis

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from _____, 19____, to _____, 19____, that I last saw the deceased alive on _____, 19____, and that death occurred at 3:30 AM, from the causes and on the date stated above.

ACTUAL SIGNATURE: Paul A. DeVore M.D. ADDRESS (Street, city or town, state): 3501 HAMILTON ST. W. Hyattsville DATE SIGNED

PHYSICIAN'S NAME (Type): PAUL A. DEVORE 3501 HAMILTON ST. W. HYATTSVILLE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-8-1961

22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM

22d. LOCATION (City, town, or county) (State): BLADENSBURG, MD

23. FUNERAL DIRECTOR'S SIGNATURE: W.W. Chambers Co ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 9 61

24b. REGISTRAR'S SIGNATURE: Clifford L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this page has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9464

CERTIFICATE OF DEATH

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: 5 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 318 Prince George St

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence prior to admission) 9456
a. STATE: Md
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanham
d. STREET ADDRESS: Washington Blvd
• IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Blanche — Middle: Florida — Last: Hasley

4. DATE OF DEATH: Month: August — Day: 25 — Year: 1961

5. SEX: F

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 9, 1889

9. AGE (In years last birthday): 72 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Home

11. BIRTHPLACE (County & State, or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Howard Redmond

14. MOTHER'S MAIDEN NAME: Sally Knalls

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unkown): no

16. SOCIAL SECURITY NO.: —

17. INFORMANT: Address: Lowe P. Hasley, Lanham Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebral Haemorrhage

DUE TO (b): with Hemiplegia

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 14 days.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug 11 1961 to Aug 25 1961, that (I) (we) last saw the deceased alive on Aug 25 1961, and that death occured at 1 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Frank R. Shipley M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type)

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 28, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cem.

23d. LOCATION (City, town or county) (State): Colmar Manor Md

24 FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson — ADDRESS: Laurel Md

25a. RECEIVED BY REGISTRAR DATE: AUG 25 61

25b. REGISTRAR'S SIGNATURE: Lindsay S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9465 — Reg. Dist. No. 09457

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 3118 Powder Mill Road

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Takoma Park
d. STREET ADDRESS: 701 Erie Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ida — Middle: Elmyra — Last: Haslup

4. DATE OF DEATH: Month: August — Day: 12th — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: October 15, 1885

9. AGE (In years last birthday): 76 yrs.

IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: At Home

11. BIRTHPLACE (State or foreign country): Baltimore Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: George E. Adams

14. MOTHER'S MAIDEN NAME: Lillie M. White

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): No
(If yes, give war or dates of service): None

16. SOCIAL SECURITY NO: None

17. INFORMANT: Vernon J. Haslup — 5429 Walton Ave. Camp Springs Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Terminal Pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH: 3 days

4 4 4.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arterio-sclerotic Heart Disease — 5 yrs.

DUE TO (c): Hypertension - — 10 yrs.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Hypo-Thyroidism. — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour: a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from June 23 19 61 to 8/12 19 61, that I last saw the deceased alive on 8/12 19 61, and that death occurred at 10:45 P M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Francis X Richardson M.D. — ADDRESS (Street, city or town, state): 1142 Viers Mill Rd — DATE SIGNED: 8/12/61

PHYSICIAN'S NAME (Type): FRANCIS X RICHARDSON — Wheaton Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-15-61

22c. NAME OF CEMETERY OR CREMATORY: George Wash. Memo.

22d. LOCATION (City, town, or county) (State): Prince George Co. Md.

23. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. — ADDRESS: 5801 Cleveland Ave. Riverdale Md

24a. REC'D BY REGISTRAR DATE: AUG 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur E. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9466

Item 11 Film G294 9/13/61 iwk

09458

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Dupont Heights
d. STREET ADDRESS: 6429 Dupont Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Maria; Middle:; Last: Hays

4. DATE OF DEATH: Month: August; Day: 29; Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH:

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months: Days:
IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Orange Co. Virginia

12. CITIZEN OF WHAT COUNTRY?

13. FATHER'S NAME: Rubin Cooper

14. MOTHER'S MAIDEN NAME: Elizabeth Cooper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Helen Hayes Address: 1334 Emerald St NE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonitis
DUE TO (b): Adeno carc. Rt colon
DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 29 1961, to August 29, 1961, that (I) (we) last saw the deceased alive on August 29 1961, and that death occurred at 11:20 A.M., from the causes and on the date stated above.

22a. SIGNATURE: C. James Duke M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒

22b. DATE SIGNED: 8/28/61

22c. PHYSICIAN'S NAME (Type): C. JAMES DUKE M.D.

22d. ADDRESS: 6607 RIVERDALE RD., RIVERDALE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: 9-2-61

23c. NAME OF CEMETERY OR CREMATORY: Harmony Park.

23d. LOCATION (City, town, or county) (State): Sharpe Rd. Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Hall Bros. ADDRESS: 621 Fla. Ave NW

25a. REC'D BY REGISTRAR DATE SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
TSM 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9467

CERTIFICATE OF DEATH

Items 13 & 14 from birth cer. 8/9/61 iwk

09459

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 9 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 8011 Greenleaf Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby — Middle: Boy — Last: Heath

4. DATE OF DEATH: Month: Aug. — Day: 3 — Year: 19 61

5. SEX: Male — 6. COLOR OR RACE: White — 7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 25 July 1961

9. AGE (In years last birthday): — yrs — IF UNDER 1 YEAR: Months: — Days: 9 — IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ralph Dean Heath
14. MOTHER'S MAIDEN NAME: Florence Elizabeth Taliaferro

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) If yes, give war or dates of service): No
16. SOCIAL SECURITY NO.: --
17. INFORMANT: Hospital Records — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Severe Atelectasis pneumonitis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from _____, 19___, to _____, 19__, that (I) (we) last saw the deceased alive on _____ 19___, and that death occurred at 11:30PM from the causes and on the date stated above.

22a. SIGNATURE: G. Hageage, M.D. — ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐ — 22b. DATE SIGNED: 8-4-61

22c. PHYSICIAN'S NAME (Type): Dr. G. Hageage., M.D.
22d. ADDRESS: Mt. Rainier., Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/7/61
23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: F. Gasch's Sons 4739 Balt. Ave, Hyattsville Md.
25a. REC'D BY REGISTRAR: AUG 9 '61
25b. REGISTRAR'S SIGNATURE: Clinton L. Reese

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death by the hospital and attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

VR A15 (4)
15M 9/59

2077318 XV3

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9468

09460

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Temple Hills
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 5424--Fisher Rd., S.E.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 26 Hillside
d. STREET ADDRESS: 1200 59th Ave. S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First MYRTIE Middle B. Last HIGH

4. DATE OF DEATH: Month Aug. Day 20 Year 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 27, 1881
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Domestic
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Edward R. Anderson
14. MOTHER'S MAIDEN NAME: Lizzie J. Spicer

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no or unknown) (If yes, give war or dates of service):
16. SOCIAL SECURITY NO.:
17. INFORMANT: Catherine E. Rosser — Address: 5424-Fisher Rd. SE Temple Hills, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Coronary Thrombosis — INTERVAL BETWEEN ONSET AND DEATH:

DUE TO (b): Arterio Sclerotic Cardio Vascular Renal — 2 years

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c): Old Age

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from Aug. 16, 1961, to Aug. 20, 1961, that (I) (we) last saw the deceased alive on Aug. 16, 1961, and that death occurred at 2 AM, from the causes and on the date stated above.

22a. SIGNATURE: Dr. Etienne Szollosi M D
ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED: Aug. 20 1961
22c. PHYSICIAN'S NAME (Type): Dr.Etienne Szollosi
22d. ADDRESS: #2 Parkway Dr., SE Forest Hghts, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: Aug 23-61
23c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
23d. LOCATION (City, town or county) (State): Culpeper, Va.

24. FUNERAL DIRECTOR'S SIGNATURE: Semmes Bro.
ADDRESS: 1661-Good Hope Rd SE Wash 20 D.C.
25a. FILED BY REGISTRAR DATE: Aug 22 61
25b. REGISTRAR'S SIGNATURE: Arthur J. Krieg

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9469 **CERTIFICATE OF DEATH** 03461

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 1Hr 20 Min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's Gen. Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: ~~Maryland~~ District of ~~Columbia~~
b. COUNTY: Columbia
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1760 Euclid St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John William; Middle: Hill; Last: Hill jr

4. DATE OF DEATH: Month: August; Day: 16; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 16,1961

9. AGE (In years last birthday): yrs. IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours 1; Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: John William Hill jr

14. MOTHER'S MAIDEN NAME: Barbara Jean Street

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mother

Address: Same

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): 762.5 Atelectasis (anoxia)

DUE TO (b): Immaturity

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from Aug. 16, 1961 to Aug. 16, 1961 that (I) (we) last saw the deceased alive on Aug. 16. 1961, and that death occured at 11:05 A.M. from the causes and on the date stated above.

22a. SIGNATURE: Louis H. Moody, Jr., M.D. MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Louis H. Moody jr., 918 Ellsworth Dr., Silver Spring, Md.

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 8/23/61

23c. NAME OF CEMETERY OR CREMATORY: Prince Geo. Gen. Hospital

23d. LOCATION (City, town or county): Cheverly, Maryland (State)

24 FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Adm.

ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 24 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained at the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9470

CERTIFICATE OF DEATH

09462

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 10 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 25 Seat Pleasent
d. STREET ADDRESS: 1109 69th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First Hattie — Middle — Last Holland
4. DATE OF DEATH: Month August — Day 18 — Year 19 61

5 SEX: Female
6 COLOR OR RACE: Black
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒
8. DATE OF BIRTH: 27 August 1913
9. AGE (In years last birthday): 47 yrs.
IF UNDER 1 YEAR / IF UNDER 24 HRS: Months — Days — Hours — Min

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Cook
10b KIND OF BUSINESS OR INDUSTRY:
11. BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: Mason Emerson
14. MOTHER'S MAIDEN NAME: Priscella Riggs

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16 SOCIAL SECURITY NO: 214-18-88430
17. INFORMANT: Priscilla Emerson — Address: Owings , Md.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Alveolar Cell Ca Lung — INTERVAL BETWEEN ONSET AND DEATH: UNKNOWN

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☑ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c TIME OF INJURY Month, Day, Year, Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from 8/8 19 61 to 8/18 19 61, that (I) (we) last saw the deceased alive on 8/18 19 61, and that death occurred at 4:15 PM from the causes and on the date stated above

22a SIGNATURE: C. James Duke M.D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☑
22b. DATE SIGNED: 8/19/61
22c PHYSICIAN'S NAME (Type): C. JAMES DUKE, MD
22d. ADDRESS: 6607 RIVERDALE RD., RIVERDALE, MD.

23a (BURIAL) CREMATION REMOVAL (Specify)
23b DATE THEREOF: 8-22-61
23c NAME OF CEMETERY OR CREMATORY: Mt. Hope
23d LOCATION (City, town, or county) (State): Sunderland , Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Kinsey E. Sewell
ADDRESS: Prince Frederick
25a. REC'D BY REGISTRAR DATE: AUG 24 '61
25b. REGISTRAR'S SIGNATURE: Arthur L Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR ATS (4) 15M 9/59

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9471 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13463

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: MARYLAND / D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WEST HYATTSVILLE MD
d. STREET ADDRESS: 6029 Sligo Creek Parkway
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Helen Middle: GERTRUDE Last: Honkonen

4. DATE OF DEATH: Month: August Day: 2 Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: JULY 16th 1916

9. AGE (In years last birthday): 45 yrs. IF UNDER 1 YEAR: Months / Days: 17 IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): SECRETARY

10b. KIND OF BUSINESS OR INDUSTRY: U.S GOVERMENT

11. BIRTHPLACE (State or foreign country): INDIANA

12. CITIZEN OF WHAT COUNTRY? U.S.A

13. FATHER'S NAME: MONROE A HOPPAS

14. MOTHER'S MAIDEN NAME: BLANCHE ONEAL

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: 287-10-8615

17. INFORMANT: RAYMONDE HONKONEN Address: 6029 SLIGO PKWY HYATTSVILLE MD

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): TRAUMATIC SUBDURAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): 936.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): MULTIPLE CONTUSIONS of BODY, FAT infiltration, liver

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒ Inquiry ☐ ☒ and in my opinion death resulted from. Natural causes ☐ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☒

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: 8/3/61

22a. BURIAL, CREMATION REMOVAL (Specify): BURIAL

22b. DATE THEREOF: 8-7-1961

22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN CEM

22d. LOCATION (City, town, or country) (State): BLADENSBURG MD

23. FUNERAL DIRECTOR ADDRESS: W. W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR DATE AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. If any delay is necessary, please explain on the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9472 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09464

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Kent Village
d. STREET ADDRESS: 2814 74th Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Edward Middle: Lee Last: Hurley
4. DATE OF DEATH: Month: August Day: 1, Year: 19 61
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: April 18,1898
9. AGE (In years last birthday): 63 yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Civil Engineer
10b. KIND OF BUSINESS OR INDUSTRY: Construction
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: Charles Edward Hurley
14. MOTHER'S MAIDEN NAME: Lilly A.Haynie
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unkown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.: 219-01-1045
17. INFORMANT: Kathryn A. Hurley, Address same #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Congestive heart failure
DUE TO (b): Myocardial infarction
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 8/1/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/4/61
22c. NAME OF CEMETERY OR CREMATORY: Baltimore National Cem.
22d. LOCATION (City, town, or country) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR ADDRESS: Howard H. Hubbard 4107 Wilkens Avenue #29
24a. REC'D BY REGISTRAR DATE: AUG 3 '61
24b. REGISTRAR'S SIGNATURE: Kathryn L. Hurley

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death where possible. Page 1 may be completed by funeral director as necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to attending physician or medical examiner. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A1SME - SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9473

CERTIFICATE OF DEATH

Reg. Dist. No. 03465

1. PLACE OF DEATH
a. COUNTY: Prince Georges' — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro
c. LENGTH OF STAY IN 1b: 2½ Mos.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Rectory Lane

2. USUAL RESIDENCE (Where deceased lived If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Pr. Geo's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: Rectory Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Evelyn — Middle B. — Last Jackson

4. DATE OF DEATH: Month August — Day 14, — Year 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: Aug. 3, 1876
9. AGE (In years last birthday): 85 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY: U. S. A.

13. FATHER'S NAME: Joseph Alvin Ridgeway
14. MOTHER'S MAIDEN NAME: Fannie Soper

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Address: Mrs. Evelyn Baden-Upper Marlboro, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral Arteriosclerosis — INTERVAL BETWEEN ONSET AND DEATH: 3 years
DUE TO
(b): Generalized Arteriosclerosis — Unk
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from 6-8, 19 61, to 8-14, 19 61, that I last saw the deceased alive on 8-14, 19 61, and that death occurred at 11:55 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: R B Sasscer M.D.
ADDRESS (Street, city or town, state): Upper Marlboro, Md.
DATE SIGNED: 8/14/61

PHYSICIAN'S NAME (Type): R. B. Sasscer, M. D.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/16/61
22c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel Cemetery
22d. LOCATION (City, town, or county) (State): Upper Marlboro, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS: Ritchie Bros. Fun'l Home-Upr Marlboro, Md
24a. RECD BY REGISTRAR DATE: AUG 22 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Hance

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9474 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 09466

~~Item 22 Film 0293~~ 8/18/61 mh

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 12 hrs
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before ed n'ssion)
a. STATE: District of Columbia
b. COUNTY
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1217 Division Ave N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

47X-3

3. NAME OF DECEASED (Type or print): First Johnnie; Middle O dell; Last Jackson
4. DATE OF DEATH: Month Aug. Day 12 Year 19 61
5. SEX: Male
6. COLOR OR RACE: Colored
7. MARRIED ☐ NEVER MARRIED ■ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 15, 1923
9. AGE (In years last birthday): 38 yrs.
IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer
10b. KIND OF BUSINESS OR INDUSTRY: Brick yard
11. BIRTHPLACE (State or foreign country): Virginia
12. CITIZEN OF WHAT COUNTRY? USA
13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Mattie Jordon (Jordan)
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.
17. INFORMANT: Mattie Jordon, same as # 2
Address

18. CAUSE OF DEATH [Enter only one cause per l ne for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): MASSIVE Intracerebral Hemorrhage
DUE TO (b): Cerebral Arteriosclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
331 IX
INTERVAL BETWEEN ONSET AND DEATH: 12 hours / YEARS
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION G VEN IN PART 1.(c)
19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCR BE HOW INJURY OCCURED. (Enter nature of injury n Part I or Part II of Item 18.)
20c. T ME OF INJURY: Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒ Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James D. Boyd M.D
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city town, or county)
DATE SIGNED: 8/12/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8-17-61
22c. NAME OF CEMETERY OR CREMATORY: Harmony Mem. Park
22d. LOCATION (City, town, or country) (State): Highland Park, Md.

23. FUNERAL D.RECTOR: Henry T. Washington & Son
ADDRESS: 4925 Alexander Rd
24a. REC'D BY REGISTRAR DATE: AUG 16 61
24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death by any doctor as necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9473

CERTIFICATE OF DEATH

8467

1 PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CHEVERLY
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: PRINCE GEORGE GENERAL Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: MARYLAND
b. COUNTY: PRINCE GEORGE
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): HYATTSVILLE
d. STREET ADDRESS: 6930 EMERSON Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: WARREN Middle: S Last: JACKSON

4. DATE OF DEATH: Month: AUGUST Day: 24 Year: 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 3/17/94

9. AGE (In years last birthday): 69 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): UNION # 132 - CARPENTER
10b. KIND OF BUSINESS OR INDUSTRY: Self
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joseph Jackson
14. MOTHER'S MAIDEN NAME: Nora Shannon

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): no (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Marie E. Jackson Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral failure — INTERVAL BETWEEN ONSET AND DEATH:
DUE TO (b): Carcinoma left lung
DUE TO (c): metastasis

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from _____, 19__, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19__, and that death occurred at _____ M. from the causes and on the date stated above.

22a. SIGNATURE: Hei K. Lee M.D
ATTENDING PHYS ☑ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED:
22c. PHYSICIAN'S NAME (Type): HEI K. LEE, M.D.
22d. ADDRESS: [redacted] 7732 Annapolis Road Lanham, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/28/61
23c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
23d. LOCATION (City, town, or county) (State): Suitland Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Hyattsville, Maryland — Hyattsville Funeral Home
25a. REC'D BY REGISTRAR DATE: AUG 28 '61
25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A1S (4)
ISM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9476 **CERTIFICATE OF DEATH** 09468

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa... may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and co...pletely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1. **PLACE OF DEATH**
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 1 yr., 8 mos., and 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. **USUAL RESIDENCE** (Where deceased lived, if institution: Rs dance before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1100 8th St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. **NAME OF DECEASED** (Type or print): First: Marguerite; Middle: E.; Last: Johnson

4. **DATE OF DEATH**: Month: 8; Day: 6; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4/1/25

9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months -, Days - IF UNDER 24 HRS.: Hours -, Min. -

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Domestic

10b. KIND OF BUSINESS OR INDUSTRY: -

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Castell Johnson

14. MOTHER'S MAIDEN NAME: Maude Glenn

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Decedent
Address: -

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a) (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Far advanced pulmonary tuberculosis
DUE TO
(b)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c)

INTERVAL BETWEEN ONSET AND DEATH: 4 yrs., 4 mo.

PART I. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 11/30/59 8:20 to 8/6/61, that (I) (we) last saw the deceased alive on 8/5/61, and that death occured at ... M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8/6/61

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)

23b. DATE THEREOF: Aug 7, 61

23c. NAME OF CEMETERY OR CREMATORY: Mt. Pleasant.

23d. LOCATION (City, town or county) (State): alodie Va.

24 FUNERAL DIRECTOR'S SIGNATURE: James E Chinn

ADDRESS: 2605 S Shirlington Rd Arlington Va

25a. REC'D BY REGISTRAR DATE: AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

5477 09469

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 3 yrs., 2 mos., & 30 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D.C.
b. COUNTY: —
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 3227 Debose Pl.,S.E.#4
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Richard; Middle: Hill; Last: Jones

4. DATE OF DEATH: Month: 8; Day: 22; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/24/1900

9. AGE (In years last birthday): 60 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Exterminator

10b. KIND OF BUSINESS OR INDUSTRY: Capital Chemical Company

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: James Jones

14. MOTHER'S MAIDEN NAME: Mary Jones

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wer or dates of service): Unknown —

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Decedent
Address:

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 002 X Pulronary tuberculosis, far advanced
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 3 yrs., 10 mo.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Fracture of left hip

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town, (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 5/23/ 12:10 1858, to 8/22/, 19 61 that (I) (we) last saw the deceased alive on 8/22/ 19 61, and that death occured at P. M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss

M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8/22/61

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/26/61

23c. NAME OF CEMETERY OR CREMATORY: Harmony

23d. LOCATION (City, town or county) (State): Glen Arden, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Johnson & Jenkins

ADDRESS: 4804 Ga. Ave. N.W.

25a. REC'D BY REGISTRAR DATE: AUG 25 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

188

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Parts 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09470

1. PLACE OF DEATH — a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laural
c. LENGTH OF STAY IN 1b: One
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 727 Bond Mill Road

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) — a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Adelphi
d. STREET ADDRESS: 1706 Keokee Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Lydia — Middle: Maria — Last: Knorr
4. DATE OF DEATH: Month: August — Day: 21 — Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: February 24, 1871
9. AGE (In years last birthday): 90 yrs.
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS.: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (State or foreign country): Pennsylvania
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Wetzel
14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give wars or dates of service): No
16. SOCIAL SECURITY NO.: None
17. INFORMANT — Address: Charles G. Knorr, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident — INTERVAL BETWEEN ONSET AND DEATH
442+
DUE TO (b): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒ and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 8/21/61

22a. BURIAL, CREMATION, REMOVAL (Specify): removal
22b. DATE THEREOF: 8/23/61
22c. NAME OF CEMETERY OR CREMATORY: Uniondale Cemetery
22d. LOCATION (City, town, or country) (State): Pittsburgh, Pa.

23. FUNERAL DIRECTOR — ADDRESS: The S.H. Hines Co. 2901 14th St. N.W. Washington 9, D.C.
24a. REC'D BY REGISTRAR — DATE: AUG 23 '61
24b. REGISTRAR'S SIGNATURE: Clarence L. Hines

1 FOR STATE HEALTH DEPT.

M

X

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any inquiry is necessary, please complete the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS-A1SME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9479

CERTIFICATE OF DEATH

Reg. Dist. No. 09471

1. PLACE OF DEATH
a. COUNTY [illegible] MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICKSBURG
c. LENGTH OF STAY IN 1b 2 years
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION [illegible]

2. USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE [illegible] b COUNTY [illegible]
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) FREDERICKSBURG
d. STREET ADDRESS 7500 KIGGS ROAD
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First NOEL Middle I Last KRUSEN

4. DATE OF DEATH Month Aug. Day 13 Year 1961

5. SEX FEMALE
6. COLOR OR RACE WHITE
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH 4-11-78
9. AGE (In years last birthday) 83 yrs
IF UNDER 1 YEAR Months Days
IF UNDER 24 HRS. Hours Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE
10b. KIND OF BUSINESS OR INDUSTRY
11. BIRTHPLACE (State or foreign country) VIRGINIA
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME JOHN L. [illegible]
14. MOTHER'S MAIDEN NAME [illegible]

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO.
17. INFORMANT [illegible] Address [illegible]

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute pulmonary Edema — INTERVAL BETWEEN ONSET AND DEATH

420.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) Arteriosclerotic Heart disease

DUE TO (c) Arteriosclerosis Generalized

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Nov. 19 59 to 13 Aug. 19 61 that I last saw the deceased alive on 10 Aug. 19 61, and that death occurred at 6 A.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Thomas P. Fogarty M.D. ADDRESS (Street, city or town, state) 1011 Univ. Blvd E Silver Spring Md DATE SIGNED 13 Aug 61

PHYSICIAN'S NAME (Type) THOMAS P. FOGARTY M.D. 1011 UNIVERSITY BLVD. E. SILVER SPRING, MD.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF 8-16-61
22c. NAME OF CEMETERY OR CREMATORY [illegible]
22d. LOCATION (City, town, or county) (State) [illegible]

23. FUNERAL DIRECTOR'S SIGNATURE J. J. Collins ADDRESS [illegible] D.C.
24a. REC'D BY REGISTRAR DATE AUG 16 '61
24b. REGISTRAR'S SIGNATURE Arthur L. Hines

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon covers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/55

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9480 **MEDICAL EXAMINER'S CERTIFICATE OF DEATH** 0947Z

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: DOA
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution, Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Boulevard Heights
d. STREET ADDRESS: 5107 Byers Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: Gary — Last: Lawrence 11

4. DATE OF DEATH: Month: August — Day: 12, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: May 30, 1957

9. AGE (In years last birthday): 4 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Miami, Florida

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: John Gary Lawrence

14. MOTHER'S MAIDEN NAME: Manoka Runyon

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: John Gary Lawrence, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to Immediate cause (a), stating the underlying cause last. DUE TO (b) ATROPY and PIGMENTATION BRAIN STEM and SPINAL CORD

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): TRACHEOBRONCHITIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/12/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 8/16/61 — 22c. NAME OF CEMETERY OR CREMATORY: Washington National — 22d. LOCATION (City, town, or country) (State): Suitland Maryland

23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. 3801 Cleveland Ave Hyattsville Md

24a. REC'D BY REGISTRAR DATE: AUG 16 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

S481 — 09473

1. **PLACE OF DEATH**
   a. COUNTY: Prince George's
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
   c. LENGTH OF STAY IN 1b: 5 days
   MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
   a. STATE: Maryland
   b. COUNTY: Prince George's
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tuxedo
   d. STREET ADDRESS: 5904 Beecher Street
   e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

3. **NAME OF DECEASED** (Type or print): First: Gertrude; Middle: F.; Last: Mann

4. **DATE OF DEATH**: Month: August; Day: 30; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 2-27-97

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (City & State, or foreign country): Brooklyn, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: unknown — Farrell

14. MOTHER'S MAIDEN NAME: unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.: 577-36-5529

17. INFORMANT: Mr. William F. Mann — Address: 3806 76th Ave. Landover Hills, Md

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Atelectasis Left Lung	
DUE TO (b)	Gastric polyposis (post op)	
DUE TO (c)		

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... to ....., 19....., that (I) (we) last saw the deceased alive on ..... 19..., and that death occured at 7:06 p.m. from the causes and on the date stated above.

22a. SIGNATURE: A. DeItz M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): A. DEITZ

22d. ADDRESS: Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 9-2-1961

23c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln

23d. LOCATION (City, town or county) (State): Bladensburg, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers Co. ADDRESS: Riverdale, Md

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9482 — 09474

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 hours
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oakcrest
d. STREET ADDRESS: 403 Locust Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Debbie — Middle: Jean — Last: Matthews

4. DATE OF DEATH: Month: August — Day: 23 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 1, 1961

9. AGE (In years last birthday) ____ yrs. — IF UNDER 1 YEAR: Months: 4 — Days — IF UNDER 24 HRS: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Glenwood Matthews

14. MOTHER'S MAIDEN NAME: Helen Powell

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mother — Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a) (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Interstitial Pneumonia — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO
(c)

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 23, 1961 to August 23, 1961, that (I) (we) last saw the deceased alive on August 23 1961, and that death occurred at 2,10, from the causes and on the date stated above.

22a. SIGNATURE: Thomas A. Christensen M.D
ATTENDING PHYS. ☐ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: Aug 26

22c. PHYSICIAN'S NAME (Type): Christensen, Thomas A., M.D.

22d. ADDRESS: 6905 Baltimore Ave., Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/26/61

23c. NAME OF CEMETERY OR CREMATORY: Bacon Chapel

23d. LOCATION (City, town, or county) (State): Cheverly Prince George's Co Md

24. FUNERAL DIRECTOR'S SIGNATURE: C. Kelly Dilly — ADDRESS: 5240 Lowell

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Curtis L. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal. And in any event, within 72 hours after death.

VR A1S (4)
1SM 9/59

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible, and in any event within 72 hours after death. If autopsy or inquest is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 4 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9483 09475

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
c. LENGTH OF STAY IN 1b: 8 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5355 Quincy Place

2. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Bladensburg
d. STREET ADDRESS: 5355 Quincy Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Maude; Middle: May; Last: McCauley

4. DATE OF DEATH: Month: August; Day: 31; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: January 9, 1900

9. AGE (In years last birthday): 61 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Washington, D.C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ebenezer Barnard

14. MOTHER'S MAIDEN NAME: Annie M. Kemp

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No
(If yes give war or dates of service): None

16. SOCIAL SECURITY NO.: 213-16-2585

17. INFORMANT: Robert B. McCauley
Address: 2101 Quebec St., Adelphi, Md.

18. CAUSE OF DEATH (Enter only one cause per line for (a) (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 443X
DUE TO (b): Acute congestive heart failure
DUE TO (c): Cardiovascular renal disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m.; Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒. Inquiry ☒. and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: August 31, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Sept 2, 1961

22c. NAME OF CEMETERY OR CREMATORY: Geo. Washington Mem

22d. LOCATION (City, town, or country) (State): Hyattsville, Maryland

23. FUNERAL DIRECTOR: W.W. Chambers & Son

ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR: DEC 6 '61

24b. REGISTRAR'S SIGNATURE: Clifton S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9484

CERTIFICATE OF DEATH

Reg. Dist. No. 19476

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LAUREL
c. LENGTH OF STAY IN 1b: 50 YRS
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 614 MONTGOMERY ST

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Md
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): SAME Laurel
d. STREET ADDRESS: 614 Montgomery St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First LEMUEL Middle BERNARD Last MERSON

4. DATE OF DEATH: Month AUG Day 28 Year 1961

5. SEX: MALE

6. COLOR OR RACE: WHITE

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: JUNE 10, 1885

9. AGE (In years last birthday): 76 yrs
IF UNDER 1 YEAR: Months ___ Days ___
IF UNDER 24 HRS: Hours ___ Min ___

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): LABORER

10b. KIND OF BUSINESS OR INDUSTRY: PLASTERING

11. BIRTHPLACE (State or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: FRANKLIN MERSON

14. MOTHER'S MAIDEN NAME: ANNIE BRIEN

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)

16. SOCIAL SECURITY NO.: 214-12-7863

17. INFORMANT: DOROTHY BAKER Address: LAUREL MD 612 MONTGOMERY ST

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: MINUTES

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): ARTERIOSCLEROSIS AND — YEARS

~~DUE TO~~

(c): ACUTE CONGESTIVE HEART FAILURE — 2 HOURS

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Month, Day, Year, Hour a. m. / p. m. 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I attended the deceased from DECEMBER 1957, to AUG 28, 1961, that I last saw the deceased alive on Aug 25, 1961, and that death occurred at 6:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: J. R. Buell M.D. ADDRESS (Street, city or town, state): 402 MAIN ST LAUREL MD DATE SIGNED: AUG 28 61

PHYSICIAN'S NAME (Type): JOHN R. BUELL

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: August 30, 61

22c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cem.

22d. LOCATION (City, town, or county) (State): Laurel Maryland

23. FUNERAL DIRECTOR'S SIGNATURE: DeWitt Donaldson ADDRESS: Laurel, Md.

24a. REC'D BY REGISTRAR DATE: SEP 6 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
ISM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9485 Reg. Dist. No. 09477

1 PLACE OF DEATH
a. COUNTY Prince Georges MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Villa Heights, Hyattsville
c. LENGTH OF STAY IN 1b 14 Yrs.
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 3814 58'th Avenue

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE Maryland b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Hyattsville
d. STREET ADDRESS 3814 58'th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print) First Mary Middle McLean Last Montgomery
4. DATE OF DEATH Month August Day 8 Year 1961

5. SEX Female
6. COLOR OR RACE White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH Sept. 25, 1882
9. AGE (In years last birthday) 78 yrs
IF UNDER 1 YEAR Months — Days —
IF UNDER 24 HRS Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife
10b. KIND OF BUSINESS OR INDUSTRY Home
11. BIRTHPLACE (State or foreign country) Wheeling, West Virginia
12. CITIZEN OF WHAT COUNTRY? U.S. of A.

13. FATHER'S NAME McLean John Ferguson
14. MOTHER'S MAIDEN NAME Philomena Schaffer

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)
16. SOCIAL SECURITY NO None
INFORMANT Mrs. Jane McCahill Address 3814 58'th Ave. Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Uremia — INTERVAL BETWEEN ONSET AND DEATH 3 days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (b) Nephro lepsis — 10 yrs.
DUE TO (c) Arteriosclerosis Generalized — 20 yrs.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
Allergy to many drugs (none for 2 yrs.)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from July, 1952, to August 5, 1961, that I last saw the deceased alive on August 6, 1961, and that death occurred at 5:40 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE Walcutt W. Gibson M.D. ADDRESS (Street, city or town, state) 4340 St. Barnabas Road DATE SIGNED Aug. 8, 1961
PHYSICIAN'S NAME (Type) Walcutt W. GIBSON, M.D. (Washington 21, D.C.) mail to In Meadow Hgts. Md.

22a. BURIAL, CREMATION, REMOVAL (Specify) Burial
22b. DATE THEREOF Aug 11, 1961
22c. NAME OF CEMETERY OR CREMATORY Ft Lincoln Cemetery
22d. LOCATION (City, town, or county) (State) Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS F. Gasch's Sons Hyattsville Md.
24a. REC'D BY REGISTRAR DATE AUG 10 '61
24b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
1SM 9/58

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9485 — 09478

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seat Pleasant
c. LENGTH OF STAY IN 1b: 12 years
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 512 69th Street

2. USUAL RESIDENCE (Where deceased lived, if inst tut on Residence before admiss on)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 24 Seat Pleasant
d. STREET ADDRESS: 512 69th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Nellie; Middle: ; Last: Papazian

4. DATE OF DEATH: Month: August; Day: 19; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1888

9. AGE (In years last birthday): 73 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): New Jersey

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Edward Papazian 1327 Spring Road N.W. Washington, D C.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b) ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE

DUE TO (c)

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER S GNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): BILATERAL INTERNAL CRANIAL OSTEOMA; FOCAL ATROPHY BRAIN

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒ and in my opinion death resulted from. Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE James I. Boyd M.D.

EXAMINER'S NAME (Type) James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED August 20, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 23, 1961

22c. NAME OF CEMETERY OR CREMATORY: Wash. National

22d. LOCATION (City, town, or country): Pr Geo. Co. (State): Md

23. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: 1400 Chapin St. N.W. Wash, D.C.

24a. REC'D BY REGISTRAR DATE AUG 23 '61

24b. REGISTRAR'S SIGNATURE Arthur L. Kraus

TO DEATH MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any inquiry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VII. A15ME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9487 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09479

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glen Arden
d. STREET ADDRESS: 1509 7th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Anthony — Middle: Lindwood — Last: Parker

4. DATE OF DEATH: Month: August — Day: 29, — Year: 1961

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: June 8, 1961

9. AGE (In years last birthday) yrs. — IF UNDER 1 YEAR: Months: 2 Days: 20 — IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Richard Brown

14. MOTHER'S MAIDEN NAME: Florence Parker

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT — Address: Florence Parker, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pneumonia
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: August 29, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify)

22b. DATE THEREOF: 9-1-61

22c. NAME OF CEMETERY OR CREMATORY: Lincoln Mem.

22d. LOCATION (City, town, or country) (State): Suitland Rd Md

23. FUNERAL DIRECTOR — ADDRESS: H.S. Washington & Son 4925 Deane Ave N.E.

24a. REC'D BY REGISTRAR DATE: SEP 5 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if possible. If any delay is necessary, please explain in the space provided. Do not write the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files

FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9488 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09460

1 PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: MARYLAND 14 hrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hosp.

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
d. STREET ADDRESS: 1610 61st Place S.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ila Middle: Dee Last: Patterson
4. DATE OF DEATH: Month: August Day: 13 Year: 1961

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: Feb. 27, 1937
9. AGE (In years last birthday): 24 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Kansas
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Unknown
14. MOTHER'S MAIDEN NAME: Opal Miller

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO
17. INFORMANT Address: Raymond Lee Patterson, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Cerebrovascular accident
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):
INTERVAL BETWEEN ONSET AND DEATH:
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.
EXAMINER'S NAME (Type): James I. Boyd
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
Address (Street, city, town, or county)
DATE SIGNED: 8/13/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: Aug 18, 1961
22c. NAME OF CEMETERY OR CREMATORY: Fairview Cemetery
22d. LOCATION (City, town, or country) (State): Phillipsburg Kansas

23. FUNERAL DIRECTOR: Hyattsville Funeral Home
ADDRESS: Hyattsville Md.
24a. REC'D BY REG STRAR DATE: AUG 17 '61
24b. REGISTRAR'S SIGNATURE: Arthur S. Hines

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9489 09481

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Florida — b. COUNTY: Franklin
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Lanark Village
d. STREET ADDRESS: 48 X 2
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Kathryn — Middle: — Last: Payne

4. DATE OF DEATH: Month: August — Day: 2 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Oct. 18, 1895

9. AGE (In years last birthday): 65 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Edward Davis

14. MOTHER'S MAIDEN NAME: Mary Louise Spicer

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Eleanor Bernice Giddens — Address: 3196 Lancer Pl Hyattsville, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute Congestive Heart Failure — INTERVAL BETWEEN ONSET AND DEATH
DUE TO
(b): Cardiovascular Renal Disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from: Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

EXAMINER'S NAME (Type): James I. Boyd

Address (Street, city, town, or county):

DATE SIGNED: 8/2/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 5, 1961

22c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery

22d. LOCATION (City, town, or country) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR — ADDRESS: F. Gasch's Sons Hyattsville, Md.

24a. REC'D BY REGISTRAR DATE: AUG 10 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any inquiry necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9490

CERTIFICATE OF DEATH

(19)482

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 3500 Bunker Hill Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: John — Middle: H. — Last: Pearson

4. DATE OF DEATH: Month: August — Day: 28 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12/6/1895

9. AGE (In years last birthday): 65 yrs
IF UNDER 1 YEAR: Months: — Days: —
IF UNDER 24 HRS: Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Guard, National Bureau of Standards

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Oneonta, N.Y.

12. CITIZEN OF WHAT COUNTRY? U.S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown):
(If yes, give war or dates of service):

16. SOCIAL SECURITY NO:

17. INFORMANT: Mrs. Etta B. Pearson, Wife — Address: above

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute coronary insufficiency — INTERVAL BETWEEN ONSET AND DEATH: 2 hours

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Arteriosclerotic H.D. — 2 years

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a): Ost. arth. ft.

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour: o m. / p m. — Month, Day, Year: 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-25-1961 to 8-28-1961, that (I) (we) last saw the deceased alive on 8-28-1961, and that death occurred at 8.50 A.M., from the causes and on the date stated above

22a. SIGNATURE: Walda B. Moyers M.D.

ATTENDING PHYS ☒ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: 8-28-61

22c. PHYSICIAN'S NAME (Type): Walda B. Moyers

22d. ADDRESS: 3503 Perry St. Mt. Rainier Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/31/61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town, or county) (State): Arlington, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE: Nalley's Funeral Home Inc.

ADDRESS: Mt. Rainier Md.

25a. REC'D BY REGISTRAR DATE: AUG 5 '61

25b. REGISTRAR'S SIGNATURE:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR AIS (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9491 — 09483

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
d. STREET ADDRESS: 4326 Van Buren Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Norman; Middle: E.; Last: Phillips

4. DATE OF DEATH: Month: August; Day: 1; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 31, 1894

9. AGE (In years last birthday): 67 yrs
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired
10b. KIND OF BUSINESS OR INDUSTRY: Brotherhood of Ry

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: —

14 MOTHER'S MAIDEN NAME: Missouri Belle

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): yes
(If yes, give war or dates of service): WW I

16. SOCIAL SECURITY NO.:

17. INFORMANT: Rachel Phillips — Address: Hyattsville Md

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Atelectasis — INTERVAL BETWEEN ONSET AND DEATH
541.0
DUE TO
(b): Massive pulmonary embolism during surgery for bleeding duodenal ulcer
DUE TO
(c):

Conditions if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o. m. / p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from July 27 1961 to August 1 1961, that (I) (we) last saw the deceased alive on August 1 1961, and that death occurred at 2:10 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Saul Schwartzbach M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Saul Schwartzbach, M.D.
22d. ADDRESS: 1726 Eye Street, N.W., Washington 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/ /61
23c. NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d. LOCATION (City, town or county) (State): Colmar Manor, Md

24. FUNERAL DIRECTOR'S SIGNATURE: F Gasch & Sons — ADDRESS: Hyattsville Md
25a. REC'D BY REGISTRAR DATE: AUG 7 '61
25b. REGISTRAR'S SIGNATURE: Clifton S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9492

CERTIFICATE OF DEATH

Item 9 Film G294 9/11/61 mh

9484

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 3 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont Heights
d. STREET ADDRESS: 725 60th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Margaret; Middle: ; Last: Prescott

4. DATE OF DEATH: Month: August; Day: 31; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 12-25-02

9. AGE (In years last birthday): 58 yrs 39

IF UNDER 1 YEAR: Months; Days. IF UNDER 24 HRS.: Hours; Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: —

11. BIRTHPLACE (State or foreign country): S. C.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Marshall Cain

14. MOTHER'S MAIDEN NAME: Laura Ann Holmes

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown): —
(If yes, give war or dates of service): —

16. SOCIAL SECURITY NO.:

17. INFORMANT: Amelia Patten (Sister) — Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cereb. Hem. - Edema

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Arth. Sclerosis Hyp. Dis.
DUE TO (c):

420.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIF.CANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour: o m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from August 31, 1961 to August 31, 19 61, that (I) (we) last saw the deceased alive on August 31 1961, and that death occurred at 7:40 p. m., from the causes and on the date stated above.

22a. SIGNATURE: C. J. Duke M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☐

22b. DATE SIGNED: August 31, 1961

22c. PHYSICIAN'S NAME (Type): Clarence J. Duke, M.D.

22d. ADDRESS: 6607 Riverdale Road, Riverdale, Maryland

23a. BUR AL CREMAT ON REMOVAL (Specify)

23b. DATE THEREOF: 9-6-61

23c. NAME OF CEMETERY OR CREMATORY: Carver Memy Park

23d. LOCAT ON (City, town or county) (State): Muirkirk Md

24. FUNERAL DIRECTOR'S SIGNATURE: H. S. Washington & Son

ADDRESS: 4935 Deane Ave.

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Esther L. Krantz

TO HOSPITAL PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 48 hours after death.

VR A1S (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9493 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09485

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Virginia — b. COUNTY: Essex
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Tappahanic k
d. STREET ADDRESS: 335 Queen Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frank — Middle: Douglas — Last: Pugh

4. DATE OF DEATH: Month: August — Day: 26 — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 17, 1935

9. AGE (In years last birthday): 26 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Laborer

10b. KIND OF BUSINESS OR INDUSTRY: Laundry

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Alfred P. Pugh

14. MOTHER'S MAIDEN NAME: Martha Green

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.: unknown

17. INFORMANT — Address: Margaret Rich, Tappahanick, Va

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 5.42X

DUE TO

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): Congestive heart failure

DUE TO

(c): Chronic Glomerular Nephritis

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐. Inspection ☒ Inquiry ☒ and in my opinion death resulted from Natural causes ☒ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city town, or county)

DATE SIGNED: 8/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-29-1961

22c. NAME OF CEMETERY OR CREMATORY: Antioch Cemetery

22d. LOCATION (City, town, or country): Essex County, Virginia (State)

23. FUNERAL DIRECTOR: W. W. Chambers

ADDRESS: Bo. Riverdale Md

24a. REC'D BY REGISTRAR — DATE: AUG 29 '61

24b. REGISTRAR'S SIGNATURE: Gilbert J. Forrest

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

3494

CERTIFICATE OF DEATH

Items 2, 6, & 9 Film G294 9/11/61 mh

10591

1. **PLACE OF DEATH** a. COUNTY: Prince Geo Co. MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Clinton Md.
c. LENGTH OF STAY IN 1b: N.B.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Southern Md. Hosp Center

2. **USUAL RESIDENCE** (Where deceased lived, if institution, give usual residence before admission) STATE: Md. COUNTY: Pr. Geo's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Silesia
d. STREET ADDRESS: 8671 Riverview Rd.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First: Baby Middle: Le Roy Last: Raum

4. **DATE OF DEATH**: Month: 8 Day: 30 Year: 1961

5. SEX: Male

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 8-30-61

9. AGE (In years last birthday) yrs. IF UNDER 1 YEAR: Months / Days IF UNDER 24 HRS.: Hours / Min. 1

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

10b. KIND OF BUSINESS OR INDUSTRY

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? US

13. FATHER'S NAME: Carthon Raum

14. MOTHER'S MAIDEN NAME: Jennie Whittington

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 7767 Prematurity
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 4½ hours

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on ..... 19....., and that death occured at .....M, from the causes and on the date stated above.

22a. SIGNATURE: Alfred R Lapin M.D.

ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ALFRED R. LAPIN, MD

22d. ADDRESS: So. Md Med Ctr Clinton, Md

23a. BURIAL, CREMATION, REMOVAL (Specify): ✓

23b. DATE THEREOF: 8-31-61

23c. NAME OF CEMETERY OR CREMATORY: U. of Md. Med. School

23d. LOCATION (City, town or county): Baltimore (State)

24. FUNERAL DIRECTOR'S SIGNATURE: Brought by Father & Stepmother ADDRESS

25a. REC'D BY REGISTRAR DATE SEP 6 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 3 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper from pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 a further number as Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9495 — 09486

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): On Baltimore and Ohio Tracks

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laural
d. STREET ADDRESS: 103 Main Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Ruby — Middle: Hart — Last: Rector

4. DATE OF DEATH: Month: August — Day: 1 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: December 24, 06

9. AGE (In years last birthday): 54 yrs. — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Morris

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unkown) (If yes give wars or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Joseph Ralph Rector — Address: 36 M Ridge Road Greenbelt, Md

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Hemorrhage and shook
DUE TO (b): Trauma multiple and severe
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Ran over by a train

20c. TIME OF INJURY: Hour: 2:11 p.m. — Month, Day, Year: 8/1 19 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): RR Tracks

20f. (City or town): Hyattsville — (County): P.G. — (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒ and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 8/1/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8-4-1961

22c. NAME OF CEMETERY OR CREMATORY: Ivy Hill Cemetery

22d. LOCATION (City, town, or country) (State): Laurel, Maryland

23. FUNERAL DIRECTOR — ADDRESS: W. W. Chambers Co. Riverdale, Md.

24a. REC'D BY REGISTRAR — DATE: AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Travis

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9495 **CERTIFICATE OF DEATH** 019487

Item 25a, Film G295 9/20/61 iwk

1. PLACE OF DEATH
a. COUNTY Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Camp Springs
c. LENGTH OF STAY IN 1b 8hrs, 20min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) USAF Hospital Andrews

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland
b. COUNTY Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Temple Hills
d. STREET ADDRESS 5819 Winston St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First — Middle — Last: Reed

4. DATE OF DEATH: Month Aug — Day 30 — Year 1961

5. SEX: Male
6. COLOR OR RACE: Cauc.
7. MARRIED ☐ NEVER MARRIED ☑ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 30 Aug. 61
9. AGE (In years last birthday) yrs — IF UNDER 1 YEAR: Months, Days — IF UNDER 24 HRS.: Hours 8, Min. 20

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None
10b. KIND OF BUSINESS OR INDUSTRY: None
11. BIRTHPLACE (County & State, or foreign country): Prince Georges, Md.
12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James A. Reed
14. MOTHER'S MAIDEN NAME: Martha L. Kirkland

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) No
(If yes give war or dates of service)
16. SOCIAL SECURITY NO.: None
17. INFORMANT (Address): Hospital Chart

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Anoxia — INTERVAL BETWEEN ONSET AND DEATH: 2 hrs
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Foetal Atalectasis — 8 hrs 20min
DUE TO
(c): Prematurity — 8 hrs 20min

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 30 Aug., 1961, to 30 Aug., 1961, that (I) (we) last saw the deceased alive on 30 Aug. 1961, and that death occured at 2:35 PM, from the causes and on the date stated above.

22a. SIGNATURE: Nicholas P. Haritos
M.D. ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☑
22b. DATE SIGNED: 30 Aug. 61
22c. PHYSICIAN'S NAME (Type) NICHOLAS P HARITOS CAPT USAF MC
22d. ADDRESS USAF Hosp., Andrews AFB, Wash. 25, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify) Cremation
23b. DATE THEREOF
23c. NAME OF CEMETERY OR CREMATORY Dist.of Columbia, D.C. Morgue
23d. LOCATION (City, town or county) (State)

24 FUNERAL DIRECTOR'S SIGNATURE — ADDRESS

25a. REC'D BY REGISTRAR DATE SEP 6 '61
25b. REGISTRAR'S SIGNATURE Esther L. Hines

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9497 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 13488

Item 8 Film 0294 9/5/61

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
c. LENGTH OF STAY IN 1b: 6 mo
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 5213 - Middleton Lane

7. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: P. G.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Camp Springs
d. STREET ADDRESS: 5213 Middleton Lane
e. IS RESIDENCE ON A FARM? YES ☐ NO ☑

3. NAME OF DECEASED (Type or print): First: Catherine — Middle: Charlotte — Last: Reid
4. DATE OF DEATH: Month: Aug — Day: 29 — Year: 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
8. DATE OF BIRTH: Nov 27, 1886
9. AGE (In years last birthday): 75 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS: Hours — Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: Own Home
11. BIRTHPLACE (State or foreign country): Kentucky
12. CITIZEN OF WHAT COUNTRY? U.S.A.
13. FATHER'S NAME: William Roper
14. MOTHER'S MAIDEN NAME: Gretchen Kurtz
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No
16. SOCIAL SECURITY NO.: 578-36-2983
17. INFORMANT: Margaret E. Heil, same as #2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b) Cardiovascular renal disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19 — 20d. INJURY OCCURRED: While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21 I **certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑ Inquiry ☑ and in my opinion death resulted from. Natural causes ☑ Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd, M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

Address (Street, city, town, or county)

DATE SIGNED: 8/29/61

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 22b. DATE THEREOF: 9/1/61 — 22c. NAME OF CEMETERY OR CREMATORY: Lorraine Cemetery — 22d. LOCATION (City, town, or country) (State): Baltimore, Maryland

23. FUNERAL DIRECTOR: Ambrose, Inc. — ADDRESS: 1328 Sulphur Sp. Rd

24a. REC'D BY REGISTRAR DATE: AUG 31 '61 — 24b. REGISTRAR'S SIGNATURE: Charlotte E. Krantz

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any autopsy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with The State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

1

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9498

CERTIFICATE OF DEATH

(1948)

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS, MD
c. LENGTH OF STAY IN 1b: 2 yrs
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF Hospital ANDREWS

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: MARYLAND
b. COUNTY: A.A. ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): LOTHIAN, MARYLAND
d. STREET ADDRESS: LOTHIAN TRAILER COURT
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Wilma — Middle: MAY — Last: ROBERTSON

4. DATE OF DEATH: Month: AUG — Day: 27 — Year: 1961

5. SEX: FEMALE

6. COLOR OR RACE: CAU

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 15 JAN 1928

9. AGE (In years last birthday): 33 yrs. — IF UNDER 1 YEAR, Months / Days — IF UNDER 24 HRS., Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): House WIFE

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): U.S.A. W. VA

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: JOHN A. DORSEY

14. MOTHER'S MAIDEN NAME: NETTIE R. NUTTER

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: MERLE A. ROBERTSON (H) — Address: WATSONS TR CT LOTHIAN, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 199X — INTERVAL BETWEEN ONSET AND DEATH: ½ hour

DUE TO (b): Cerebral metastasis — 6-8 Weeks

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (c): Carcinoma ? primary site unknown — 6-8 Months

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour, a.m. p.m. — Month, Day, Year, 19 — 20d. INJURY OCCURRED While at work ☐ Not While at work ☐ — 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) (County) (State)

21. **I certify** that ● (this hospital) attended the deceased from 23 August, 1961 to 27 August, 1961, that ● (we) last saw the deceased alive on 27 August, 1961, and that death occured 5:25 A.M., from the causes and on the date stated above.

22a. SIGNATURE: William S Miller M.D.

22b. DATE SIGNED: 27 August 1961

ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒

22c. PHYSICIAN'S NAME (Type): WILLIAM S. MILLER

22d. ADDRESS: US Air Force Hospital, Andrews AFB, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial-transit — 23b. DATE THEREOF: 8-28-61 — 23c. NAME OF CEMETERY OR CREMATORY: Shenandoah Mem. Park. — 23d. LOCATION (City, town or county) (State): Winchester, Virginia.

24. FUNERAL DIRECTOR'S SIGNATURE: ROBERT A. PUMPHREY — ADDRESS: Bethesda, Md.

25a. RECD. BY REGISTRAR DATE: AUG 30 '61

25b. REGISTRAR'S SIGNATURE: Arthur S. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After items certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1 2

FOR STATE HEALTH DEPT.

M

X

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any inquiry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9499

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

(13490)

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel
c. LENGTH OF STAY IN 1b: D.O.A.
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Warren's Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Howard
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Guilford
d. STREET ADDRESS: Cleary Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Hoyle — Middle: Roy — Last: Roe

4. DATE OF DEATH: August 16, 1961 (Month, Day, Year)

5. SEX: Male

6. COLOR OR RACE: Colored

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: May 26, 1897

9. AGE (In years last birthday): 64 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Race Horse Groom

10b. KIND OF BUSINESS OR INDUSTRY: Racing

11. BIRTHPLACE (State or foreign country): Georgia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes
(If yes give war or dates of service): WWI

16. SOCIAL SECURITY NO: 132-03-4535

17. INFORMANT: Mary Louise Roe — Address: Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO
(b): Hypertensive heart disease
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from. Natural causes ☒ Accident ☐ Suicide ☐ Homicide ☐ Undetermined manner ☐

ACTUAL SIGNATURE: James I Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: August 16, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/21/61

22c. NAME OF CEMETERY OR CREMATORY: Balto National

22d. LOCATION (City, town, or country): Baltimore (State): Md

23. FUNERAL DIRECTOR: Ridgley Selby — ADDRESS: 502-4th St Laurel

24a. REC'D BY REGISTRAR DATE: AUG 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Krauss

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9500 — 09491

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 8 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institutional Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: P.O. Box 171
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: Pindell — Last: Sasscer

4. DATE OF DEATH: Month: August — Day: 15 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 21 June 1907

9. AGE (In years last birthday): 54 yrs.
IF UNDER 1 YEAR — Months: — Days: —
IF UNDER 24 HRS. — Hours: — Min.: —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Economic Analyst

10b. KIND OF BUSINESS OR INDUSTRY: U. S. Government

11. BIRTHPLACE (County & State, or foreign country): Dist.of Columbia

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Robert M. Pindell

14. MOTHER'S MAIDEN NAME: Lida Gardner

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service): ---

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: B. Leale Sasscer- Upper Marlboro, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Adenocarcinoma - ovary & metastases.
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b):
DUE TO
(c):
INTERVAL BETWEEN ONSET AND DEATH: Unk.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY — Hour: — a.m. / p.m. — Month, Day, Year: — 19

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 **I certify** that (I) (this hospital) attended the deceased from 1 July, 1961, to 15 Aug, 1961, that (I) (we) last saw the deceased alive on 15 Aug 1961, and that death occured at 10:35 A.M. from the causes and on the date stated above.

22a. SIGNATURE: R.R. Sasscer M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 8/15/61

22c. PHYSICIAN'S NAME (Type): Dr.R. Sasscer., M.D.

22d. ADDRESS: Upper Marlboro., Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/18/61

23c. NAME OF CEMETERY OR CREMATORY: Trinity Cemetery

23d. LOCATION (City, town or county) (State): Upper Marlboro Md.

24. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: Ritchie Bros. Upper Marlboro

25a. REC'D BY REGISTRAR — DATE: AUG 22 '61

25b. REGISTRAR'S SIGNATURE: Arthur I. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be furnished by the funeral director, but the medical certification must be completed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9501 — 09492

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 Days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General Hospital

2 USUAL RESIDENCE (Where deceased lived If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park 20
d STREET ADDRESS: 8905 48th Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First Samuel — Middle — Last SCHWARTZ ~~Swartz~~
4. DATE OF DEATH: Month Aug. — Day 5 — Year 1961
5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: May 28, 1885
9. AGE (In years last birthday): 76 yrs.
IF UNDER 1 YEAR: Months — Days
IF UNDER 24 HRS.: Hours — Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired Clerk
10b. KIND OF BUSINESS OR INDUSTRY: Post Office
11 BIRTHPLACE (State or foreign country): Maryland
12 CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Samuel G. Schwartz
14. MOTHER'S MAIDEN NAME: Alice Peters

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No — (If yes, give war or dates of service): --
16. SOCIAL SECURITY NO: -------
17 INFORMANT: Mary (wife) — Address: same

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): (1) Bilateral Bronchopneumonia — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): (2) Arteriosclerotic heart disease — 5 yrs
DUE TO (c): Disease of Decompensation
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19 WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year, Hour o. m. p. m. 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 8-2 1961 to 8-5 1961 that (I) (we) last saw the deceased alive on 8-5 1961 and that death occurred at 2:45 P.M. from the causes and on the date stated above.

22a. SIGNATURE: W. L. Etienne M.D
ATTENDING PHYS. ☒ MED DIRECTOR ☐ STAFF PHYS ☐
22b. DATE SIGNED: 8-5-61
22c. PHYSICIAN'S NAME (Type): W. L. ETIENNE
22d ADDRESS: College Park Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: 8/7/61
23c NAME OF CEMETERY OR CREMATORY: Ft. Lincoln Cemetery
23d LOCATION (City, town, or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE ADDRESS: F. Gasch's Sons 4739 Balt. Ave Hyattsville, Md.
25a REC'D BY REGISTRAR DATE: AUG 10 '61
25b REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 1SM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any inquiry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9502 — 09493

1. PLACE OF DEATH
e. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hillside
c. LENGTH OF STAY IN Ib: Fewx Hours
d. NAME OF HOSP.TA. OR INSTITUTION (If not in hospital, give street address): Oak Crest Country Club

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): District Heights
d. STREET ADDRESS: 7201 Cabot Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Phillip — Middle: William — Last: Siemer Jr

4. DATE OF DEATH: Month: August — Day: 26, — Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: Feb. 11, 1929

9. AGE (In years last birthday): 32 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Statician

10b. KIND OF BUSINESS OR INDUSTRY: U.S. Census

11. BIRTHPLACE (State or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U. S. A.

13. FATHER'S NAME: Phillip William Siemer Sr

14. MOTHER'S MAIDEN NAME: Lois Wile

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary Gertrude Siemer, Same as # 2 — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE CARDIAC FAILURE
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): SEVERE OCCLUSIVE CORONARY ATHEROSCLEROSIS
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Acute TRACHEOBRONCHITIS

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒. Inspection ☒. Inquiry ☒. and in my opinion death resulted from: Natural causes ☒. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: 8/26/61

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

22b. DATE THEREOF: AUG 30TH 1961

22c. NAME OF CEMETERY OR CREMATORY: HOLY CROSS CEMETERY

22d. LOCATION (City, town, or country) (State): CLEVELAND OHIO

23. FUNERAL DIRECTOR — ADDRESS: W. W. CHAMBERS Co RIVERDALE MD
5801 - CLEVELD AVE

24a. REC'D BY REGISTRAR DATE: AUG 29 '61

24b. REGISTRAR'S SIGNATURE: Arthur I. Kruse

1

(M)

(C)

(I)

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9503

CERTIFICATE OF DEATH

09494

1. PLACE OF DEATH a. COUNTY: PRINCE GEORGES, MARYLAND	2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE: MARYLAND b. COUNTY: PRINCE GEORGES
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE; c. LENGTH OF STAY IN 1b: 2 DAYS	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): UPPER MARLBORO
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): USAF HOSPITAL ANDREWS	d. STREET ADDRESS: RFD, BOX 2034; e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print) First: ROBERT Middle: Last: SIKORSKI

4. DATE OF DEATH Month: AUGUST Day: 14 Year: 1961

5. SEX: MALE
6. COLOR OR RACE: CAUCASIAN
7. MARRIED ☐ NEVER MARRIED XX WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: 11 AUGUST 1961
9. AGE (In years last birthday) yrs.; IF UNDER 1 YEAR Months / Days: 3; IF UNDER 24 HRS. Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE
10b. KIND OF BUSINESS OR INDUSTRY: NONE
11. BIRTHPLACE (County & State, or foreign country): MARYLAND
12. CITIZEN OF WHAT COUNTRY?: UNITED STATES

13. FATHER'S NAME: RICHARD WILLIAM SIKORSKI
14. MOTHER'S MAIDEN NAME: RUTH JOSEPHINE GEARY

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO
16. SOCIAL SECURITY NO.: NONE
17. INFORMANT: MEDICAL RECORDS Address: USAF HOSP, ANDREWS AFB, MD

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)	Anoxia	Immediate
DUE TO (b)	Atelectasis, congenital	2 days
DUE TO (c)	Immaturity	2 Days

762.5

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not While at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that (I) (~~this hospital~~) attended the deceased from 11 August, 1961, to 14 August, 1961, that (I) (we) last saw the deceased alive on 14 August 1961, and that death occured at 206A M, from the causes and on the date stated above.

22a. SIGNATURE: Richard P. Malsan M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22b. DATE SIGNED: 14 Aug 61
22c. PHYSICIAN'S NAME (Type): RICHARD P MALSAN, Captain USAF MC
22d. ADDRESS: USAF HOSPITAL, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE THEREOF: 8/15/61
23c. NAME OF CEMETERY OR CREMATORY: Arlington Nat'l Cem.
23d. LOCATION (City, town or county) (State): Ft. Myer, Virginia

24. FUNERAL DIRECTOR'S SIGNATURE / ADDRESS: Ritchie Bros. Fun'l Home-Upr Marlboro, Md.
25a. REC'D BY REGISTRAR DATE: AUG 22 '61
25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page may be retained by hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9504 — 09495

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince Georges General Hosp. — STREET ADDRESS: 3123 Queens Chapel Road
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

2. USUAL RESIDENCE (Where deceased lived, If institution, Res'dence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier +

3. NAME OF DECEASED (Type or print): First: James — Middle: A. — Last: Sinyard

4. DATE OF DEATH: Month: Aug — Day: 6 — Year: 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 10-29-'96

9. AGE (In years last birthday): 65 yrs. — UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Crane Operator

10b. KIND OF BUSINESS OR INDUSTRY: Davis Sand + Gravel Co.

11. BIRTHPLACE (County & State or foreign country): Pa.

12. CITIZEN OF WHAT COUNTRY? America

13. FATHER'S NAME: John Sinyard

14. MOTHER'S MAIDEN NAME: Laura Sensinger

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): NO (If yes give wer or dates of service)

16. SOCIAL SECURITY NO.

17. INFORMANT: Elda Sinyard — Address: Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremia
DUE TO (b): Cancer of Rectum — INTERVAL BETWEEN ONSET AND DEATH: 10 Mos.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. [Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from 1 July, 1961 to 6 Aug, 1961 that (I) (~~last~~) saw the deceased alive on 6 Aug, 1961, and that death occured at 12:35 M, from the causes and on the date stated above.

22a. SIGNATURE: A.W. McLaurin — M.D. — ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6 Aug '61

22c. PHYSICIAN'S NAME (Type): A. W. McLaurin

22d. ADDRESS: 4637 Eastern Ave. Hyattsville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: aug 9 1961

23c. NAME OF CEMETERY OR CREMATORY: Gradenhuetten

23d. LOCATION (City, town or county) (State): Lehighton Pa.

24. FUNERAL DIRECTOR'S SIGNATURE: F Brooks Sons — ADDRESS: Hyattsville Md

25a. REC'D BY REGISTRAR DATE: AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Charles L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pa... may be retained ... hospital or attending physician.

TO FUNERAL DIRECTOR: After ... certificate has been signed by the attending physician and ... ete... ed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

8505 Item 9 Film 0292 8/16/61 mh 09496

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
d. STREET ADDRESS: 2609 Crest Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

42

3. NAME OF DECEASED (Type or print): First: Ada; Middle: Mae; Last: Smith
4. DATE OF DEATH: August 9, 1961
5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: January 10, 1880
9. AGE (In years last birthday): 81 84 yrs.
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: own home
11. BIRTHPLACE (State or foreign country): West Va
12. CITIZEN OF WHAT COUNTRY? U S A
13. FATHER'S NAME: James Wilson
14. MOTHER'S MAIDEN NAME: Palestine Zinn
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)
16. SOCIAL SECURITY NO.:
17. INFORMANT: Mrs Nell Mc Gowan Address: Cheverly Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]

		INTERVAL BETWEEN ONSET AND DEATH
PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)	Fatal Edema.	
DUE TO (b)	Acute epilepti	
DUE TO (c)	Diabetes Mellitus (Chr	

Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21 I certify that (I) (this hospital) attended the deceased from Aug. 5 1961 to Aug. 9 1961, that (I) (we) last saw the deceased alive on Aug. 9 1961, and that death occurred at 9:20 P.M. from the causes and on the date stated above.

22a SIGNATURE: James L Laubach M D
ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒
22b. DATE SIGNED: August 9, 1961
22c. PHYSICIAN'S NAME (Type): James L. Laubach, M.D.
22d. ADDRESS: 1806 Fox St., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b DATE THEREOF: Aug 11, 1961
23c NAME OF CEMETERY OR CREMATORY: Ft Lincoln Cemetery
23d LOCATION (City town, or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons ADDRESS: Hyattsville Md.
25a REC'D BY REGISTRAR DATE: AUG 11 '61
25b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

TO HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A1S (4)
15M 9/58

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9505

CERTIFICATE OF DEATH

Reg. Dist. No. 1947

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
c. LENGTH OF STAY IN 1b: Since 1934
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: 3806-30th Street

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince Georges
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier + 7
d. STREET ADDRESS: 3806-30th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Frances — Middle: B. — Last: Smith

4. DATE OF DEATH: Month: 8 — Day: 27 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9/29/83?

9. AGE (In years last birthday): 78 yrs
IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: own home

11. BIRTHPLACE (State or foreign country): Fulton Co. Georgia

12. CITIZEN OF WHAT COUNTRY? U. S.

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)

16. SOCIAL SECURITY NO. (If yes, give war or dates of service): 575-03-4258

INFORMANT: Alma B. Smith — Address: above — Husband

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinomatosis of Abdomen — INTERVAL BETWEEN ONSET AND DEATH: 3 months
DUE TO
(b): Primary site undetermined — 1 year
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Arteriosclerotic Heart disease

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY: Hour, a. m. / p. m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f (City or town) (County) (State)

21. I certify that I attended the deceased from 6-24, 1961, to 8-27, 1961, that I last saw the deceased alive on 8-25, 1961, and that death occurred at 11:15 M, from the causes and on the date stated above.

ACTUAL SIGNATURE: Waldo B. Moyers M.D. — ADDRESS (Street, city or town, state): 3503 Perry St. — DATE SIGNED: 8-28-61

PHYSICIAN'S NAME (Type): Waldo B. Moyers — Mt. Rainier, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/30/61

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

22d. LOCATION (City, town, or county) (State): Colmar Manor, Md.

23. FUNERAL DIRECTOR'S SIGNATURE: Malley's Funeral Home, Inc. — ADDRESS: Mt. Rainier, Md

24a. REC'D BY REGISTRAR DATE: AUG 31 '61

24b. REGISTRAR'S SIGNATURE: Arthur S. Kraus

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

9507 — Reg. Dist. No. 09498

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Ritchie
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George Co. Rest Home

2. USUAL RESIDENCE (Where deceased lived. If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): X Upper Marlboro
d. STREET ADDRESS: Box 2580
e. IS RESIDENCE ON A FARM? YES ☒ NO ☐

3. NAME OF DECEASED (Type or print): First James Middle Henry Last Smith

4. DATE OF DEATH: Month August Day 18th Year 1961

5. SEX: Male
6. COLOR OR RACE: White
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: February 21st 1878
9. AGE (In years last birthday): 83 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS: Hours / Min

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Farmer
10b. KIND OF BUSINESS OR INDUSTRY: Tabacco
11. BIRTHPLACE (State or foreign country): Maryland
12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: Charles W. Smith
14. MOTHER'S MAIDEN NAME: Mary Frances Boatley

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown): No (If yes, give war or dates of service): None
16. SOCIAL SECURITY NO.: 579-22-3503H
17. INFORMANT: Charles W. Smith Address: Box 2580 Upper Marlboro Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Acute Congestive Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days
DUE TO (b): Arteriosclerotic Myocarditis — unknown
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last
DUE TO (c): General Arteriosclerosis (Senile) — Unknown
4221

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): None of note
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☑

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Natural Causes
20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)

21. I certify that I attended the deceased from Feb 1, 1961, to Aug 18, 1961, that I last saw the deceased alive on Aug 18, 1961, and that death occurred at 3:45 P.M., from the causes and on the date stated above.
ACTUAL SIGNATURE: Paul C VanNatta M.D. — ADDRESS (Street, city or town, state): 5480 Silver Hill Rd S.E. — DATE SIGNED
PHYSICIAN'S NAME (Type): PAUL C VAN NATTA — Washington 28 D.C.

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial
22b. DATE THEREOF: 8/22/61
22c. NAME OF CEMETERY OR CREMATORY: Cedar Hill
22d. LOCATION (City, town, or county) (State): Suitland Maryland

23. FUNERAL DIRECTOR'S SIGNATURE — ADDRESS: W. W. Chambers Co. 517 11th St. S.E. DC
24a. REC'D BY REGISTRAR DATE: AUG 23 '61
24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
ISM 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9508 — 09499

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN: 30 min
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial Hospital

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Pro George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Colmar Manor, Md.
d. STREET ADDRESS: 3406 - 39th Ave.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Marie — Middle: — Last: Sodeman

4. DATE OF DEATH: Month: 8 — Day: 17 — Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☐

8. DATE OF BIRTH: 6-10-1899

9. AGE (In years last birthday): 62 yrs. — IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Ohio

12. CITIZEN OF WHAT COUNTRY?: U.S.A.

13. FATHER'S NAME: John V. Poras

14. MOTHER'S MAIDEN NAME: Susan ?

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no

16. SOCIAL SECURITY NO.:

17. INFORMANT — Address: Benson G. Sodeman Same as #2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): a Coronary Thrombosis
DUE TO (b): Arteriosclerotic Heart Dis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): Diabetes

INTERVAL BETWEEN ONSET AND DEATH: 1½ hr. / 6 yrs / 5

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(c): Diabetes

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1956, 19—, to Aug 17, 1961, that (I) (~~we~~) last saw the deceased alive on Aug 17, 1961, and that death occured at 3:45 A.M., from the causes and on the date stated above.

22a. SIGNATURE: L W Malin

22b. DATE SIGNED: Aug 17-1961

22c. PHYSICIAN'S NAME (Type): L W Malin M.D.

M.D. ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS: Riverdale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/19/61

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town or county) (State): Colmar Manor, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons

ADDRESS: Hyattsville, Md.

25a. REC'D BY REGISTRAR DATE: AUG 21 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9509 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09500

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George'
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Seabrook
d. STREET ADDRESS: 9401 DuBarry
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William; Middle: Randall; Last: Steep

4. DATE OF DEATH: Month: August; Day: 18; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: September 3/35

9. AGE (In years last birthday): 25 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Truck Driver

10b. KIND OF BUSINESS OR INDUSTRY: Hauling

11. BIRTHPLACE (State or foreign country): West Virginia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Orr Steep

14. MOTHER'S MAIDEN NAME: Virginia Madeline Robertson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes give war or dates of service): 52 to 56

16. SOCIAL SECURITY NO.:

17. INFORMANT: 9511 Fontana Dr Carol Ann Belden, Lanham, Md

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO
(b): Drowning
DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. [Enter nature of injury in Part I or Part II of item 18.]: Was swimming and got a cramp disappearing in water

20c. TIME OF INJURY: Hour: 10:00 PM; Month, Day, Year: 8/18 61

20d. INJURY OCCURRED: While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Blue Pond

20f. (City or town): Muirkirk (County): P.G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county):

DATE SIGNED: August 19, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug 22, 1961

22c. NAME OF CEMETERY OR CREMATORY: Evergreen Cemetery

22d. LOCATION (City, town, or country): Bladensburg (State): Md.

23. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME
SM 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9516

CERTIFICATE OF DEATH

09501

1 PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland b. COUNTY: Prince George

b. CITY OR TOWN (If outside corporate limits write RURAL and give nearest town): Hyattsville
c. LENGTH OF STAY IN 1b: 10 yrs.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Hyattsville

d NAME OF HOSPITAL (If not in hospital give street address) OR INSTITUTION: 4101 Jefferson St.
d STREET ADDRESS: 4101 Jefferon St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Sallie Middle: A Last: Stein
4. DATE OF DEATH: Month: August Day: 25 Year: 19 61

5. SEX: Female
6. COLOR OR RACE: White
7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐
8. DATE OF BIRTH: July 29, 1881
9. AGE (In years last birthday): 80 yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife
10b. KIND OF BUSINESS OR INDUSTRY: -----
11. BIRTHPLACE (State or foreign country): Washington, D.C.
12 CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Lemuel W. Sanderson
14. MOTHER'S MAIDEN NAME: Sarah M. Murphy

15 WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
16. SOCIAL SECURITY NO
17 INFORMANT: Mrs. Esther Blundon Daughter Address 4101 Jefferson St.

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b) and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH: 1 week
DUE TO (b): Generalized arteriosclerosis — 10 yrs.
Conditions, if any which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

450.0

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Rheumatoid arthritis, generalized, 10 yrs duration
19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18): None
20c TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19
20d. INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21 I certify that (I) (my associate) attended the deceased from Feb. 23 1949, to Aug. 25 1961, that (I) ~~am~~ last saw the deceased alive on Aug. 24 19 61 and that death occurred at 10:20 A M, from the causes and on the date stated above

22a. SIGNATURE: George Dewey, M.D.
ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS ☐
22b DATE SIGNED: Aug. 25, 1961
22c PHYSICIAN'S NAME (Type): George Dewey, M.D.
22d. ADDRESS: 1629 Columbia Rd NW Wash 9 DC

23a BURIAL CREMATION REMOVAL
23b DATE THEREOF: 8/28/61
23c NAME OF CEMETERY OR CREMATORY: Congressional Cem.
23d LOCATION (City, town, or county): E. St. Washington, D.C.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home ADDRESS: 300-4th St. N.E. Wash D.C.
25a REC'D BY REGISTRAR DATE: AUG 29 '61
25b REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A1S (4) ISM 9/59

1

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if any inquiry is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

9511 — 095112

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Oxon Run
d. STREET ADDRESS: 2202 Chadwick S.E.
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Rosetta; Middle: Gazelle; Last: Stewart

4. DATE OF DEATH: Month: August; Day: 17; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [XX] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: July 25, 1910

9. AGE (In years last birthday): 51 yrs. IF UNDER 1 YEAR: Months / Days. IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: U.S.Govt

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Frank A. Stephan

14. MOTHER'S MAIDEN NAME: Anna Kanya

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: Donald Aubrey Stewart, same as # 2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): HEPATIC FAILURE
DUE TO
(b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I.a)

19. WAS AUTOPSY PERFORMED? YES [X] NO [ ]

20a. EXTERNAL CAUSE WAS PRIMARY [ ] or CONTRIBUTING [ ] CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy [X] Inspection [X] Inquiry [X] and in my opinion death resulted from: Natural causes [ ] Accident [ ] Suicide [ ] Homicide [ ] Undetermined manner [X]

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER [ ]
ASSISTANT MEDICAL EXAMINER [ ]
DEPUTY MEDICAL EXAMINER [X]

Address (Street, city, town, or county)

DATE SIGNED: August 17, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: Aug. 21, 1961

22c. NAME OF CEMETERY OR ~~XXXXX~~: Arlington National

22d LOCATION (City, town, or country) (State): Arlington, Virginia.

23. FUNERAL DIRECTOR ADDRESS: W. W. CHAMBERS CO. Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 21 '61

24b. REGISTRAR'S SIGNATURE: Arthur I. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9512

CERTIFICATE OF DEATH

09503

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After the physician's certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
ISM 9/60

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If institution, Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
d. STREET ADDRESS: 6626 Powhatan St.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alice; Middle: R.; Last: Stoulil

4. DATE OF DEATH: Month: August; Day: 17; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: August 29, 1891

9. AGE (In years if under 1 year last birthday): 69 yrs | Months | Days | Hours | Min. | IF UNDER 24 HRS.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed, Cook.

10b. KIND OF BUSINESS OR INDUSTRY: Sacred Heart Rectory

11. BIRTHPLACE (County & State or foreign country): Washington D.C

12. CITIZEN OF WHAT COUNTRY? USA.

13. FATHER'S NAME: John Bain

14. MOTHER'S MAIDEN NAME: Jannie Cardosa

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO

17. INFORMANT: Georgia Schmid

Address: Same as #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Right hemothorax — Interval between onset and death: Minutes

DUE TO

4500

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b) Aneurysm of right axillary artery with rupture — Unknown

DUE TO

(c) Arteriosclerosis — Unknown

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from August 12, 1961 to August 17, 1961, that (I) (we) last saw the deceased alive on August 17, 1961, and that death occured at 1:00 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Barry Rosenberg M.D.

ATTENDING PHYS ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Barry Rosenberg, M.D.

22d. ADDRESS: 1210 Chillum Manor Rd., West Hyattsville, M

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-21-1961

23c. NAME OF CEMETERY OR CREMATORY: Glenwood Cemetery

23d. LOCATION (City, town or county) (State): Washington, D.C

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. CHAMBERS CO.,

ADDRESS: Riverdale, Md.

25a. REC'D BY REGISTRAR DATE: AUG 23 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9513

CERTIFICATE OF DEATH

09504

1. **PLACE OF DEATH**
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CAMP SPRINGS
c. LENGTH OF STAY IN 1b: 8 DAYS
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS AFB, MARYLAND

2. **USUAL RESIDENCE** (Where deceased lived, If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA — b. COUNTY: ✓
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 3755 JAY ST, NE
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: ANDY — Middle: A — Last: STRICKLAND

4. DATE OF DEATH: Month: AUGUST — Day: 23 — Year: 1961

5. SEX: MALE

6. COLOR OR RACE: NEGROID

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 20 April 1920

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): US AIR FORCE

10b. KIND OF BUSINESS OR INDUSTRY: AIRMAN

11. BIRTHPLACE (County & State, or foreign country): NEW JERSEY

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: GORDON STRICKLAND

14. MOTHER'S MAIDEN NAME: CLEO STRICKLAND

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): YES

16. SOCIAL SECURITY NO.: 151-18-0874

17. INFORMANT: Hospital Records — Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC ARREST. — INTERVAL BETWEEN ONSET AND DEATH: Immediate
DUE TO
(b): CONVULSION — Immediate
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO
(c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED: While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — 20f. (City or town) — (County) — (State)

21 **I certify** that (I) (~~XXXXXXX~~) attended the deceased from 16 Aug, 1961, to 23 Aug, 1961, that (I) (~~XXX~~) last saw the deceased alive on 23 Aug 1961, and that death occured at 1045 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Kenneth P Carlson M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 23 Aug 61

22c. PHYSICIAN'S NAME (Type): KENNETH P CARLSON CAPT USAF MC

22d. ADDRESS: USAF HOSPITAL ANDREWS AFB, MARYLAND

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 28 Aug. 61

23c. NAME OF CEMETERY OR CREMATORY: Arlington National

23d. LOCATION (City, town or county) (State): Arlington, Va.

24 FUNERAL DIRECTOR'S SIGNATURE: B.F. Truslow Jr.

ADDRESS

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Clarence L. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9514

CERTIFICATE OF DEATH

09505

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death

VR A1S (4)
1SM 9/59

1 PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2 USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Laurel 01
d. STREET ADDRESS: 611 8th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3 NAME OF DECEASED (Type or print): First: Edna — Middle: L. — Last: Thomas

4. DATE OF DEATH: Month: August — Day: 21 — Year: 1961

5 SEX: Female

6. COLOR OR RACE: Negro

7. MARRIED ☐ **NEVER MARRIED** ☒ **WIDOWED** ☐ **DIVORCED** ☐

8 DATE OF BIRTH: May 5, 1905

9. AGE (In years last birthday): 56 yrs

IF UNDER 1 YEAR: Months: — Days: — IF UNDER 24 HRS.: Hours: — Min.:

10a USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Unemployed

10b. KIND OF BUSINESS OR INDUSTRY:

11 BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY?:

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15 WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Hospital records

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Rt. intra cerebral Hemorrhage — INTERVAL BETWEEN ONSET AND DEATH:

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO (b): Hypertensive Art. Sel. Ht dis.

DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes Mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18.)

20c TIME OF INJURY Hour: a. m. / p. m. — Month: — Day: — Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.):

20f. (City or town) (County) (State):

21. I certify that (I) (this hospital) attended the deceased from August 1, 1961, to August 21, 1961, that (I) (we) last saw the deceased alive on August 21, 1961 and that death occurred at 11:20 from the causes and on the date stated above.

22a SIGNATURE: W H Clements M.D

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ A.H.

22b DATE SIGNED: August 22, 1961

22c PHYSICIAN'S NAME (Type): William H. Clements, M.D.

22d. ADDRESS: 6001 35th Avenue, Hyattsville, Maryland

23a BURIAL, CREMATION, REMOVAL (Specify): Burial

23b DATE THEREOF: 8/25/61

23c NAME OF CEMETERY OR CREMATORY: Queens Chapel-

23d. LOCATION (City, town, or county) (State): Muirkirk, Md.

24 FUNERAL DIRECTOR'S SIGNATURE: Robert L. Snowden

ADDRESS: Rockville Md.

25a RECD BY REGISTRAR DATE: SEP 5 '61

25b REGISTRAR'S SIGNATURE: Arthur L. Krause

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09506

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fort Foote
c. LENGTH OF STAY IN MARYLAND: Transient
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Potomac River

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Pennsylvania
b. COUNTY: Lycoming
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Renova
d. STREET ADDRESS: 427 St. Clair Ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Charles; Middle: Thomas; Last: Thrasher

4. DATE OF DEATH: Month: Aug.; Day: 16; Year: 19 61

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: April 12,1925

9. AGE (In years last birthday): 36 yrs. IF UNDER 1 YEAR: Months / Days; IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Equipment Operator

10b. KIND OF BUSINESS OR INDUSTRY: Construction

11. BIRTHPLACE (State or foreign country): Kentuckey

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Alvas Thrasher

14. MOTHER'S MAIDEN NAME: Lena Sallee

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): Yes (If yes, give war or dates of service): WW II

16. SOCIAL SECURITY NO: 402-28-9363

17. INFORMANT: Address: Mae Thrasher, same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Asphyxia
DUE TO (b): Pinned under the water by tractor
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a).

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☒ or CONTRIBUTING ☐ CAUSE OF DEATH

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.): Pinned under the water by tractor

20c. TIME OF INJURY: Hour: 12:20P; Month, Day, Year: 8/16/ 19 61

20d. INJURY OCCURRED: While at work ☒ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): River

20f. (City or town) (County) (State): Fort Foote, P.G. Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒ Inquiry ☒; and in my opinion death resulted from: Natural causes ☐. Accident ☒. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

NAME (Type): James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

DATE SIGNED: 8/16/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/18/1961

22c. NAME OF CEMETERY OR CREMATORY: North Bend Cemetery

22d. LOCATION (City, town, or country) (State): Renovo, Clinton Co., Penna.

23. FUNERAL DIRECTOR ADDRESS: W.W.Chambers Company, 517--11th St.S.E.Wash.DC

24a. REC'D BY REGISTRAR DATE: AUG 23 '61

24b. REGISTRAR'S SIGNATURE: Clifford L. Travis

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. Type or write with pen and ink, using the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be returned for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AT5ME
5M 9 60

1

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9515 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09507

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): 4010 - 38th., Street

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Brentwood
d. STREET ADDRESS: 4010 - 38th., Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Mabel Middle: Veronica Last: Tucker

4. DATE OF DEATH: August 8th., 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: December 30, 1895

9. AGE (In years last birthday): 65 yrs. IF UNDER 1 YEAR: Months, Days. IF UNDER 24 HRS.: Hours, Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY: Own Home

11. BIRTHPLACE (State or foreign country): District of Columbia

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: James Frank Anderson

14. MOTHER'S MAIDEN NAME: Mary Barry

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): Yes (If yes, give war or dates of service): WWI

16. SOCIAL SECURITY NO.: None

17. INFORMANT Address: William Fredrick Tucker, same as # 2

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): 442 ☒

DUE TO (b): Acute congestive heart failure

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c): C ardiovascular renal disease

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒ Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

Address (Street, city, town, or county)

DATE SIGNED: Aug. 8, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/11/61

22c. NAME OF CEMETERY OR CREMATORY: Arlington National

22d. LOCATION (City, town, or country): Arlington (State): Va.

23. FUNERAL DIRECTOR: F. Gasch's Sons

ADDRESS: Hyattsville, Maryland

24a. REC'D BY REGISTRAR DATE: AUG 10 '61

24b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If death is unexpected, unnatural or unattended by physician, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to Inspector. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9517 09508

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Fairmont Heights
d. STREET ADDRESS: 1116 62nd Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print) First	Middle	Last	4. DATE OF DEATH Month	Day	Year
Sol		Underwood	August	9	1961

5. SEX	6. COLOR OR RACE	7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	8. DATE OF BIRTH	9. AGE (In years last birthday)	IF UNDER 1 YEAR Months	Days	IF UNDER 24 HRS Hours	Min
Male	Negro		February 14, 1885	76 yrs				

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)	10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
Laborer		Perry County, Alabama	U.S.A

13. FATHER'S NAME	14. MOTHER'S MAIDEN NAME
Jeff Underwood	Underwood

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) [If yes, give war or dates of service]	16. SOCIAL SECURITY NO	17. INFORMANT Address
NO		Mary Underwood 1116 62nd Pl. NE

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary Edema — DUE TO
(b): Carcinoma Selenate Ht Dis. — DUE TO
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m.	Month, Day, Year 19	20d. INJURY OCCURRED While at work ☐ Not while at work ☐	20e. PLACE OF INJURY (Home, farm factory, street, office bldg., etc.)	20f (City or town)	(County)	(State)

21. I certify that (I) (this hospital) attended the deceased from August 9, 1961, to August 9, 1961, that (I) (we) last saw the deceased alive on August 9 1961, and that death occurred at 10:30 from the causes and on the date stated above.

22a. SIGNATURE: James L. Laubach M.D.
ATTENDING PHYS ☐ MED. DIRECTOR ☐ STAFF PHYS ☑ A.M.E.
22b. DATE SIGNED: August 9, '61

22c. PHYSICIAN'S NAME (Type): James L. Laubach, M.D.
22d. ADDRESS: 1806 Fox St., Hyattsville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City, town, or county) (State)
Burial	8-14-61	Nat Harmony Pks.	Highland PK Md

24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H.S. Washington & Son 4985 Deane Ave NE	AUG 11 '61	Lucinda S. Kenna

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

FOR STATE HEALTH DEPT.

M

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9519 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09509

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General

2. USUAL RESIDENCE (Where deceased lived, If institution: Res dence before admission)
a. STATE: California
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Long Beach
d. STREET ADDRESS: 2784 Delta Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

43 X-2

3. NAME OF DECEASED (Type or print): First: Fenton; Middle:; Last: Veley

4. DATE OF DEATH: Month: August; Day: 2; Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: June 13, 1870

9. AGE (In years last birthday): 91 yrs. IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Watchman

10b. KIND OF BUSINESS OR INDUSTRY: Building

11. BIRTHPLACE (State or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Minard Veley

14. MOTHER'S MAIDEN NAME: Charlotte Burt

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Guy Veley Address: Bowie, Md.

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Aneurysm left Femoro Thoracic
DUE TO (b): Traumatic (Fall) injury to the thorax
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell down stairs in home of son

20c. TIME OF INJURY Hour a.m. p.m.: 5:00 Month: 8 Day: 1 Year: 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town) Lanham Severn Rd., (County) Bowie, Md. (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☒, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☐. Accident ☐. Suicide ☐. Homicide ☐. Undetermined manner ☐

ACTUAL SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): James I. Boyd, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐

DATE SIGNED: August 2, 1961

Address (Street, city, town, or county): 8200 Marlboro Pike, Md.

22a. BURIAL, CREMATION, REMOVAL (Specify): Transportation 7/3/61

22b. DATE THEREOF:

22c. NAME OF CEMETERY OR CREMATORY: Long Beach

22d. LOCATION (City, town, or country) (State): California

23. FUNERAL DIRECTOR: F. Gasch's Sons ADDRESS: Hyattsville Md.

24a. REC'D BY REGISTRAR DATE: AUG 7 '61

24b. REGISTRAR'S SIGNATURE: Catherine L. Knowles

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death if possible. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 only to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form MM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal; and in any event within 72 hours after death.

VS. A1SME 5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9519 — 49510

1. PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 12 yrs., 4 mos., & 7 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 1433 Decatur St., N.W.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Christine — Middle: J. — Last: Vine

4. DATE OF DEATH: Month: 8 — Day: 8 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: white

7. MARRIED ☐ **NEVER MARRIED** ☐ **WIDOWED** ☐ **DIVORCED** ☒

8. DATE OF BIRTH: 11/3/1918

9. AGE (In years last birthday): 42 yrs. — IF UNDER 1 YEAR: Months —, Days — — IF UNDER 24 HRS.: Hours —, Min. —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Receptionist

10b. KIND OF BUSINESS OR INDUSTRY: Officers Service Club 17 & R. St., N.W. D.C.

11. BIRTHPLACE (County & State, or foreign country): Va.

12. CITIZEN OF WHAT COUNTRY?: USA

13. FATHER'S NAME: Bloonfield M. Joynes

14. MOTHER'S MAIDEN NAME: Rosa Elliott

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No — (If yes give war or dates of service): -

16. SOCIAL SECURITY NO.: Unknown

17. INFORMANT: Decedent — Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Pulmonary tuberculosis — INTERVAL BETWEEN ONSET AND DEATH: 12 yrs.,

DUE TO (b):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ **OR CONTRIBUTING** ☐ **CAUSE OF DEATH** (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. — Month, Day, Year 19 —

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) — **20f.** (City or town) — (County) — (State)

21. I certify that (I) (this hospital) attended the deceased from 4/1/ 3:03 1949., to 8/8/, 19.61, that (I) (we) last saw the deceased alive on 8/7/ 19.61., and that death occured at 1 P.M., from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8/8/61

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital, Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 8/10/61

23c. NAME OF CEMETERY OR CREMATORY: Oakland Cemetery Hampton, Va.

23d. LOCATION (City, town or county) (State): HAMPTON, VIRGINIA

24 FUNERAL DIRECTOR'S SIGNATURE: W. W. Chambers

ADDRESS: Ryidale Md 5201 Cleveland Av.

25a. REC'D BY REGISTRAR DATE: AUG 14 '61

25b. REGISTRAR'S SIGNATURE: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Personal data may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

9520

CERTIFICATE OF DEATH

INFORMATION from Birth Cert. 09511

1. PLACE OF DEATH
a. COUNTY: Prince George's
MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospitol, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier 4)
d. STREET ADDRESS: 3320 Chauncey Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Baby Girl; Middle:; Last: Wade

4. DATE OF DEATH: Month: August; Day: 28; Year: 1961

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: August 28, 1961

9. AGE (In years last birthday) --- yrs.
IF UNDER 1 YEAR: Months: Days: IF UNDER 24 HRS.: Hours: 6 Min:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Cheverly, Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Ulysses P. Wade

14. MOTHER'S MAIDEN NAME: Ethel Powell

15. WAS DECEASED EVER IN U S ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT: Mother (Ethel Wade) Address: Same

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a): Respiratory Failure

DUE TO (b): Micro cephaly (congenital)

DUE TO (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 753.1

INTERVAL BETWEEN ONSET AND DEATH

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour: o. m. p. m. Month: Day: Year: 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I **certify** that (I) (this hospital) attended the deceased from August 28, 1961 to August 28, 1961 that (I) (we) last saw the deceased alive on August 28, 1961 and that death occurred at 3:30 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Wm Greco M.D.

ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 29, 1961

22c. PHYS CIAN S NAME (Type): William R. Greco, M.D.

22d. ADDRESS: 3303 Perry Street, Mt. Rainier, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Cremation

23b. DATE THEREOF: 9-1-61

23c. NAME OF CEMETERY OR CREMATORY: Prince George's Gen.Hosp.

23d. LOCATION (City, town or county) (State): Cheverly, Maryland

24. FUNERAL DIRECTOR'S SIGNATURE: Harry W. Penn, Jr., Administrator

ADDRESS:

25a. REC'D BY REGISTRAR DATE: SEP 5 '61

25b. REGISTRAR'S SIGNATURE: Arthur L. Krause

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed in all items, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9521 — Item 9 Film G294 — 9/5/61 mh — 09512

1 PLACE OF DEATH
a. COUNTY: Prince Georges — MARYLAND

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland — b. COUNTY: Prince Georges

b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly

c. LENGTH OF STAY IN 1b: 31 days

c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Upper Marlboro

d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince Georges General Hospital

d. STREET ADDRESS: Rt. 1 Box 1321

e. IS RESIDENCE ON A FARM? YES ☐ NO ☐

3. NAME OF DECEASED (Type or print): First: Bessie — Middle: — Last: Washington

4. DATE OF DEATH: Month: Aug. — Day: 27 — Year: 19 61

5. SEX: Female

6. COLOR OR RACE: Black

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1 Nov. 1885

9. AGE (In years last birthday): 75 yrs

IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: Housewife

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Henry Slye

14. MOTHER'S MAIDEN NAME: Celia Dodson

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service): No

16. SOCIAL SECURITY NO: None

17. INFORMANT — Address: John W. Washington, Box 1321 Upper Marl.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Adeno carcinoma Colon — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Mets from CA of Breast.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) — 19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)

20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21 I **certify** that (I) (this hospital) attended the deceased from Aug 6 19 61 to Aug 27 19 61 that (I) (we) last saw the deceased alive on Aug 27 19 61, and that death occurred at 6:30 PM from the causes and on the date stated above.

22a. SIGNATURE: Francis Carillo M.D. — ATTENDING PHYS ☐ MED DIRECTOR ☐ STAFF PHYS ☒ — 22b. DATE SIGNED: 8/28/61

22c. PHYSICIAN'S NAME (Type): Francis Carillo, M.D.

22d. ADDRESS: 1013 University Blvd., East Langley Pk., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial — 23b. DATE THEREOF: 8-31-61 — 23c. NAME OF CEMETERY OR CREMATORY: Mt. Carmel — 23d. LOCATION (City, town, or county) (State): Upper Marlboro, Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Ellis — ADDRESS: 4339 Hunt Pl. N.E.

25a. RECD BY REGISTRAR DATE: AUG 31 '61 — 25b. REGISTRAR'S SIGNATURE: Arthur E. Krause

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be removed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely executed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9522

CERTIFICATE OF DEATH

09513

1. PLACE OF DEATH
a. COUNTY: Prince Georges
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Glenn Dale (rural)
c. LENGTH OF STAY IN 1b: 1 month and 9 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Glenn Dale Hospital

2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission)
a. STATE: D. C.
b. COUNTY: -
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington
d. STREET ADDRESS: 533 Tenn., Ave., N.E.
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): (also known as "Carroll") Carlos K. Washington (Last)

4. DATE OF DEATH: Month 8 Day 19 Year 1961

5. SEX: Male

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 7/17/16

9. AGE (In years last birthday): 45 yrs.
IF UNDER 1 YEAR: Months -- Days --
IF UNDER 24 HRS.: Hours -- Min. --

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk (sales)

10b. KIND OF BUSINESS OR INDUSTRY: Republic Market

11. BIRTHPLACE (County & State, or foreign country): Washington, D. C.

12. CITIZEN OF WHAT COUNTRY? U. S. A.

13. FATHER'S NAME: George Washington

14. MOTHER'S MAIDEN NAME: Ella Frye

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No -

16. SOCIAL SECURITY NO.: 579-16-1232

17. INFORMANT: Decedent
Address

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pulmonary tuberculosis
DUE TO (b):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 7 yrs., 7 mos.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Pulmonary emphysema and fibrosis

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 7/10/ 7:02 1961 to 8/19/ ..., 1961, that (I) (we) last saw the deceased alive on 8/19/ 19 61, and that death occured at P. M, from the causes and on the date stated above.

22a. SIGNATURE: Moe Weiss M.D.

ATTENDING PHYS. ☐ MED. DIRECTOR ☒ STAFF PHYS. ☐

22b. DATE SIGNED: 8/19/1961

22c. PHYSICIAN'S NAME (Type): Moe Weiss, M. D.

22d. ADDRESS: Glenn Dale Hospital Glenn Dale, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8/24/61

23c. NAME OF CEMETERY OR CREMATORY: Lincoln Memorial

23d. LOCATION (City, town or county) (State): Suitland, Maryland

24 FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: W. E. Jarvis Co 1432 Yor Rd

25a. REC'D BY REGISTRAR DATE: AUG 25 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Mills

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completed by the funeral director, page 1 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9523 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09514

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND 2 Days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution. Res dence before adm ssion)
a. STATE: Maryalnd
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mt. Rainier
d. STREET ADDRESS: 3508 Shepherd
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Daisey Middle: Ingersoll Last: Watts

4. DATE OF DEATH: Month: August Day: 8, Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒

8. DATE OF BIRTH: March 22,1878

9. AGE (In years last birthday): 83 yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Clerk

10b. KIND OF BUSINESS OR INDUSTRY: Retired

11. BIRTHPLACE (State or foreign country): Kansas

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Robert Ingersoll

14. MOTHER'S MAIDEN NAME: Bretta Dean

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): No

16. SOCIAL SECURITY NO.:

17. INFORMANT Address: Elinor D. Garilla, Same as # 2

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): Acute congestive heart failure — INTERVAL BETWEEN ONSET AND DEATH

DUE TO (b): Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c):

I 2 0.0

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I: Fracture of right femur and left humerus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒ XX

MEDICAL CERTIFICATION

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH. ☒

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.): Fell in home

20c. TIME OF INJURY Hour: 10:60 a.m. ~~p.m.~~ XX Month, Day, Year: 8/6/ 19 61

20d. INJURY OCCURRED While at work ☐ Not While at work ☒

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.): Home

20f. (City or town): Mt. Rainier (County): P. G. (State): Md

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒XX and in my opinion death resulted from: Natural causes ☐, Accident ☒, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE James D. Boyd M.D.

EXAMINER'S NAME (Type) James I. Boyd

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

8/8/61

Address (Street, city, town, or county)

22a. BURIAL, CREMATION, REMOVAL (Specify): Burial

22b. DATE THEREOF: 8/9/61

22c. NAME OF CEMETERY OR CREMATORY: Fort Lincoln Cem.

22d. LOCATION (City, town, or country) (State): Colmar Manor. Md.

23. FUNERAL DIRECTOR: Nalley's Funeral Home, Inc.

ADDRESS: Mt. Rainier Md.

24a. REC'D BY REGISTRAR DATE: AUG 11 '61

24b. REGISTRAR'S SIGNATURE: Charles S. Kraus

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If deaths are numerous, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME 5M 7/59

BP

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9524

CERTIFICATE OF DEATH

09515

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGES — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): ANDREWS AIR FORCE BASE
c. LENGTH OF STAY IN 1b: 1 DAY
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): USAF HOSPITAL ANDREWS

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: DISTRICT OF COLUMBIA
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d. STREET ADDRESS: 5213 CANTERBURY WAY
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First JOHN — Middle OWEN — Last WELSH

4. DATE OF DEATH: Month AUGUST — Day 1 — Year 19 61

5. SEX: MALE

6. COLOR OR RACE: CAUCASIAN

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 31 JULY 1961

9. AGE (In years last birthday): yrs. — IF UNDER 1 YEAR: Months — Days 1 — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): NONE

10b. KIND OF BUSINESS OR INDUSTRY: NONE

11. BIRTHPLACE (County & State, or foreign country): MARYLAND

12. CITIZEN OF WHAT COUNTRY? UNITED STATES

13. FATHER'S NAME: THOMAS GLENN ALBERT WELSH

14. MOTHER'S MAIDEN NAME: MARY LOUISE MCQUAID

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give wer or dates of service): NO

16. SOCIAL SECURITY NO: NONE

17. INFORMANT: FATHER — Address: SAME AS ITEM #2

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 7609 Intracranial hemorrhage
DUE TO (b): Irreversible hypoxia
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: 29 hrs

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☒ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that ☒ (this hospital) attended the deceased from 31 July, 1961, to 1 Aug, 1961, that ☒ (we) last saw the deceased alive on 1 Aug 1961, and that death occured at 6:25 P.M. from the causes and on the date stated above.

22a. SIGNATURE: John A Moore MD

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 1 AUG 61

22c. PHYSICIAN'S NAME (Type): JOHN A MOORE, Major USAF MC

22d. ADDRESS: USAF HOSP, ANDREWS AIR FORCE BASE, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL

23b. DATE THEREOF: 4 AUG. 1961

23c. NAME OF CEMETERY OR CREMATORY: ARLINGTON NATIONAL

23d. LOCATION (City, town or county) (State): ARLINGTON VA.

24. FUNERAL DIRECTOR'S SIGNATURE: Michael J. Lindli

ADDRESS: Lindli Funeral Home 916 H St NE

25a. REC'D BY REGISTRAR: AUG 4 '61

25b. REGISTRAR'S SIGNATURE: Clinton L. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

YR A15 (4)
15M 9/60

1

FOR STATE HEALTH DEPT.

M

I

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death, if necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. AISME SM 9 60

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9525 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09516

1. PLACE OF DEATH
a. COUNTY: Prince George's
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: MARYLAND
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Prince George's General Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Mount Rainier
d. STREET ADDRESS: 3619 Eastern Avenue
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Bertha; Middle: ; Last: Wettig

4. DATE OF DEATH: Month: August; Day: 15; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: March 16, 1884

9. AGE (In years last birthday): 77 yrs.
IF UNDER 1 YEAR: Months: ; Days: ; # UNDER 24 HRS.: Hours: ; Min.:

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None - RETIRED CHARWOMAN

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A,

13. FATHER'S NAME: Henry Sears

14. MOTHER'S MAIDEN NAME: UNKNOWN

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service)

16. SOCIAL SECURITY NO.: UNKNOWN

17. INFORMANT: Thomas L. Sears, same as # 2
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Acute congestive heart failure
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b): Coronary heart disease
DUE TO
(c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☒, Inquiry ☒, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒

SIGNATURE: James I. Boyd M.D.

EXAMINER'S NAME (Type): JAMES I. BOYD, M.D.

Address (Street, city, town, or county):

DATE SIGNED: August 15, 1961

22a. BURIAL, CREMATION, REMOVAL (Specify): ENTOMBMENT

22b. DATE THEREOF: 8-18-61

22c. NAME OF CEMETERY OR CREMATORY: FORT LINCOLN

22d. LOCATION (City, town, or county) (State): BLADENSBURG MARYLAND

23. FUNERAL DIRECTOR: W. W. Chambers Co.
ADDRESS: Riverdale, Md.

24a. REC'D BY REGISTRAR DATE: AUG 17 '61

24b. REGISTRAR'S SIGNATURE: Arthur L. Kruse

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9526

CERTIFICATE OF DEATH

1951

1. PLACE OF DEATH
a. COUNTY: Prince George
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Riverdale
c. LENGTH OF STAY IN 1b: 6 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Eugene Leland Memorial

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): College Park
d. STREET ADDRESS: 8112 51st ave
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: White, Middle: Elsie B., Last: White

4. DATE OF DEATH: Month: 8, Day: 23, Year: 1961

5. SEX: F

6. COLOR OR RACE: Negro

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐

8. DATE OF BIRTH: 12-19-1896

9. AGE (In years last birthday): 64 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): maid

10b. KIND OF BUSINESS OR INDUSTRY: Domestic

11. BIRTHPLACE (County & State, or foreign country): Md

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Joe Nickens

14. MOTHER'S MAIDEN NAME: Alice Baltimone

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): NO

16. SOCIAL SECURITY NO.:

17. INFORMANT: Record Office
Address: 4408 Queensbury, Rd.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a): Cerebral hemorrhage
DUE TO (b): Arterial sclerosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Indeterminate

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Diabetes mellitus

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from aug 17, 1961 to aug 23, 1961, that (I) (we) last saw the deceased alive on aug 23, 1961, and that death occured at 6 P.M. from the causes and on the date stated above.

22a. SIGNATURE: L W Malin M.D.

22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): L.W. Malin M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22d. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 8-29-61

23c. NAME OF CEMETERY OR CREMATORY: Nat Harmony Mem Pk

23d. LOCATION (City, town or county) (State): Higland Pk. Md

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: H.S. Washington & Son 4925 Deane Ave NE

25a. REC'D BY REGISTRAR DATE: AUG 28 '61

25b. REGISTRAR'S SIGNATURE: Clinton S. Evans

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
1M 9/

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9527

CERTIFICATE OF DEATH

Item 2 Film G293 8/25/61 mh

49518

1. **PLACE OF DEATH**
   a. COUNTY: PRINCE GEORGES — MARYLAND
   b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): CLINTON
   c. LENGTH OF STAY IN 1b:
   d. NAME OF HOSP.TAL OR INSTITUTION (If not in hospital, give street address): So MD. HOSPITAL CENTER

2. **USUAL RESIDENCE** (Where deceased lived. If inst tution: Residence before adm ssion)
   a. STATE: WASHINGTON — b. COUNTY: D. C.
   c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Washington SE
   d. STREET ADDRESS: 2813 Buena Vista Terrace — CLINTON MD. — RESIDENCE ON A FARM? YES ☐ NO ☐

3. **NAME OF DECEASED** (Type or print): First FREDERICK — Middle N — Last WILSON SR

4. **DATE OF DEATH**: Month AUGUST — Day 15 — Year 1961

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☑ — NEVER MARRIED ☐ — WIDOWED ☐ — DIVORCED ☐

8. DATE OF BIRTH: 3-26-20

9. AGE (In years last birthday): 41 yrs. — IF UNDER 1 YEAR: Months — Days — IF UNDER 24 HRS.: Hours — Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): U.S POST. OFFICE

10b. KIND OF BUSINESS OR INDUSTRY: FEDERAL EMPLOYEE CLERK

11. BIRTHPLACE (County & State, or foreign country): FROSTBURG, MD.

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Geo Wilson

14. MOTHER'S MAIDEN NAME: Eufala ? Wilson

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 217-107928

17. INFORMANT: Gladys Wilson wife — Address: 2813 Buena Vista Terrace S.E.

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CEREBRAL HEMORRHAGE — INTERVAL BETWEEN ONSET AND DEATH: 15 MINUTES
DUE TO (b): THROMBOCYTOPENIA PURPURA IN CRISIS — 10 DAYS
DUE TO (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

MEDICAL CERTIFICATION

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II. of item 18.)

20c. TIME OF INJURY — Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED — While at work ☐ — Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from ..... 19..... to ..... 19....., that (I) (we) last saw the deceased alive on Aug 15 19 61, and that death occured at 8:20 P.M. from the causes and on the date stated above.

22a. SIGNATURE: Alfred R Lapen M.D. — ATTENDING PHYS. ☑ — MED. DIRECTOR ☐ — STAFF PHYS. ☐ — 22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): ALFRED R. LAPEN M.D.

22d. ADDRESS: CLINTON, MD.

23a. BURIAL, ~~CREMATION~~, REMOVAL (Specify) — 23b. DATE THEREOF: 8-18-61 — 23c. NAME OF CEMETERY OR CREMATORY: Arl Nat Cem — 23d. LOCATION (City, town or county) (State): Ft Myer - Va -

24. FUNERAL DIRECTOR'S SIGNATURE: J.W. Key. — ADDRESS: Wash D.C.

25a. REC'D BY REGISTRAR DATE: AUG 18 61 — 25b. REGISTRAR'S SIGNATURE: Clinton L. Thomas

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page [illegible] may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/60

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

9528

CERTIFICATE OF DEATH

Reg. Dist. No. 09513

1. PLACE OF DEATH
a. COUNTY: PRINCE GEORGE — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): KENSINGTON
c. LENGTH OF STAY IN 1b:
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: CARROLL HALL SANT.

2 USUAL RESIDENCE (Where deceased lived — If institution: Residence before admission)
a. STATE: DC
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): WASHINGTON
d STREET ADDRESS: 1227 MADISON ST NW
e IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ELEANOR Middle — Last WOLTER
4 DATE OF DEATH: Month AUGUST Day 1 Year 1961
5. SEX: FEMALE
6. COLOR OR RACE: WHITE
7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
8. DATE OF BIRTH: MARCH 10, 1881
9. AGE (In years last birthday): 80 yrs
IF UNDER 1 YEAR: Months — Days —
IF UNDER 24 HRS: Hours — Min —

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): HOUSEWIFE
10b KIND OF BUSINESS OR INDUSTRY: HOME
11 BIRTHPLACE (State or foreign country): WASHINGTON DC
12. CITIZEN OF WHAT COUNTRY: USA

13. FATHER'S NAME: GEORGE HAGAN
14 MOTHER'S MAIDEN NAME: BARBARA LACY

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) — (If yes, give war or dates of service) —
16. SOCIAL SECURITY NO. —
17 INFORMANT: ANDREW H WOLTER Address: 1227 MADISON NW

MEDICAL CERTIFICATION

18 CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac failure — INTERVAL BETWEEN ONSET AND DEATH: 2 days

DUE TO (b) Arterio-sclerosis — 7

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 450.0

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)
20c. TIME OF INJURY Hour o. m. p. m. Month, Day, Year 19
20d INJURY OCCURRED While at work ☐ Not while at work ☐
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f (City or town) (County) (State)

21. I certify that I attended the deceased from April 1, 1961, to Aug 1, 1961, that I last saw the deceased alive on July 31, 1961, and that death occurred at 4:35 P.M., from the causes and on the date stated above.

ACTUAL SIGNATURE: Walter K. Anguine, M.D. ADDRESS (Street, city or town, state): 6300 13th St NW WASH DC DATE SIGNED

PHYSICIAN'S NAME (Type): WALTER K ANGUINE

22a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
22b DATE THEREOF: Aug 4, 1961
22c. NAME OF CEMETERY OR CREMATORY: Rock Creek
22d. LOCATION (City town, or county) (State): WASHINGTON DC

23 FUNERAL DIRECTOR'S SIGNATURE: Neal Funeral Home ADDRESS: 481 Harvard NW Wash DC
24a. REC'D BY REGISTRAR DATE: AUG 3 '61
24b. REGISTRAR'S SIGNATURE: Esther S. Krauss

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 10/57

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

9529 (09520)

1. PLACE OF DEATH
a. COUNTY: Prince George's — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 27 days
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION: Prince George's General

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George's
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Capitol Heights
d. STREET ADDRESS: 1008 Books Raod
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Alma; Middle: N; Last: Yocum

4. DATE OF DEATH: Month: August; Day: 7; Year: 19 61

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 9-9-97

9. AGE (In years last birthday): 63 yrs.
IF UNDER 1 YEAR: Months; Days
IF UNDER 24 HRS.: Hours; Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Ret. U.S. Govt.

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (State or foreign country): Penna.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: William Price

14. MOTHER'S MAIDEN NAME: Martha Davis

15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT (Address): Betty Geier

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Pul. CMS Edema
DUE TO (b): Congestive Failure,
DUE TO (c): Biliary Cirrhosis
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
581.0

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a):

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☐

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a. m. p. m.; Month; Day; Year 19

20d. INJURY OCCURRED: While at work ☐ Not while at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from July 12, 1961, to August 7, 1961, that (I) (we) last saw the deceased alive on August 7, 1961, and that death occurred at 1:00 p.m. from the causes and on the date stated above.

22a. SIGNATURE: Saul Schwartzbach M.D.
ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☐
22b. DATE SIGNED

22c. PHYSICIAN'S NAME (Type): Saul Schwartzbach, M.D.

22d. ADDRESS: 1726 Eye Street, N.W., Washington 6, D.C.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug. 11, 1961

23c. NAME OF CEMETERY OR CREMATORY: Ft. Lincoln

23d. LOCATION (City, town, or county) (State): Bladensburgh Md.

24. FUNERAL DIRECTOR'S SIGNATURE: Lee Funeral Home
ADDRESS: 300-4th St. NE Wash DC

25a. REC'D BY REGISTRAR DATE AUG 10 '61

25b. REGISTRAR'S SIGNATURE: Clifton S. Kruse

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

9530

CERTIFICATE OF DEATH

09521

1. PLACE OF DEATH
a. COUNTY: Prince George — MARYLAND
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town): Cheverly
c. LENGTH OF STAY IN 1b: 2 days
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address): Prince George General

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Prince George
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): 19 Hyattsville
d. STREET ADDRESS: 5027 37th Place
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: Albert — Middle: J — Last: Zyvoloski

4. DATE OF DEATH: Month: August — Day: 27 — Year: 1961

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 4-8-91

9. AGE (In years last birthday): 70 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Retired

10b. KIND OF BUSINESS OR INDUSTRY: U S Government

11. BIRTHPLACE (County & State, or foreign country): Pennsylvania

12. CITIZEN OF WHAT COUNTRY? U S A

13. FATHER'S NAME: Unknown

14. MOTHER'S MAIDEN NAME: Unknown

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): yes — (If yes give war or dates of service): W W 1

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mary E Zyvoloski — Address: Hyattsville Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a): Carcinoma of Lung & Metastasis

163X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b): to Rt. Lung.

DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH:

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (~~this hospital~~) attended the deceased from July 1, 1961, to Aug 27, 1961, that (I) (we) last saw the deceased alive on Aug 26 1961, and that death occured at 9:12 AM, from the causes and on the date stated above.

22a. SIGNATURE: A Deitz M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: August 27, 1961

22c. PHYSICIAN'S NAME (Type): Dr. Aaron Deitz

22d. ADDRESS: 4314 Gallatin Street

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: Aug 30, 1961

23c. NAME OF CEMETERY OR ~~XXXXXX~~: Arlington National

23d. LOCATION (City, town or county) (State): Arlington Virginia

24 FUNERAL DIRECTOR'S SIGNATURE: F. Gasch's Sons — ADDRESS: Hyattsville Md.

25a. REC'D BY REGISTRAR DATE: 8 29 61

25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60